Records Release Consent

I authorize:

_____

Dentist/Doctor Name

_____

Office Street Address City/State/Zip Code

Office Phone Office Fax Office Email

To release my records relevant to dental treatment, or copies of such, and request they be transferred to:

Renée L. I. Owen, D.D.S.
2024 Lansing Rd Charlotte MI 48813
Ph. 517-543-5230 Email: charlottemidds@gmail.com

Patient Name (Print):_____Ph:_____

Address: _____

_____

Signature of Patient/Parent/Guardian Relationship to Patient Date

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