Records Release Request

Date: _____

To: _____
Doctor / Physician

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Martin Whitson, D.M.D.
P.O. Box 577 -- Dandridge, TN 37725
Telephone: (865) 397-2956
Fax: (865) 397-5589

Print name of patient Date of Birth

Signature (patient, parent, guardian)