RECORDS RELEASE REQUEST

Date_____

To_____
(Dental Provider's Name)

Address_____

City_____State_____Zip_____

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

Dr. Tamara Abbett D.D.S.
940 Ellendale Drive
Medford, OR. 97504
Office #: 541-779-9059
Office Fax #: 541-779-0226

Please E-mail Records to: hygiene@abbettdds.com

_____
Print Name of Patient

_____
Signature (Patient, Parent or Guardian)