SALIDA
FAMILY DENTISTRY
Advanced Technology. Friendly Staff.

DATE OF REQUEST_____

MY PERMISSION IS GRANTED TO DR.

FORMER DENTIST_____

PHONE NUMBER_____FAX NUMBER_____

CITY_____ STATE_____EMAIL_____

TO DISCLOSE ALL CURRENT RECORDS, XRAYS, AND INFORMATION REGARDING DENTAL FINDINGS AND TREATMENT OF

PATIENT NAME_____

PATIENT DOB_____

TO:

SALIDA FAMILY DENTISTRY
7600 W. HWY 50
SALIDA, CO 81201
719-539-2587
719-539-4169 FAX
WEBSITE: www.dentistinsalida.com

PATIENT SIGNATURE_____

PLEASE EMAIL RECORDS/XRAYS TO:

sfdreceive@gmail.com