LEGACY
DENTAL GROUP

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REQUEST FOR MEDICAL/DENTAL RECORDS

Patient Name(s) _____

Address _____

I authorize the release of dental/medical record information regarding the above named patient(s) to Dr. John Mills, Dr. Jeffrey Grabiel, and/or Dr. Raymond Kim.

This authorization is valid until expressly revoked by the undersigned.

_____ _____
Signature of Patient or Patient's Legal Representative **Date**

Previous Dental Office:
(Please print clearly)

Name_____

Phone_____

Email_____

FOR OFFICE USE ONLY

BW _____ ☐ sending FMX/Panx_____ ☐ sending

Requested By _____ Date _____