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## Records Release Authorization

I respectfully request that you release the complete dental history records that you have on file concerning the treatment of the patient listed below. Please forward any digital images in jpeg format to:

Dentist \_\_\_\_\_

Dentist Telephone #: \_\_\_\_\_

Dentist Email: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date

Sincerely,  
Dr. David H. Brantley  
Dr. John W. Spratling  
Dr. Will Brantley  
Dr. Rachel Elvis