

# RECORDS RELEASE/REQUEST

To \_\_\_\_\_  
(Doctor/Hospital)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize the release of my dental records, or copies of such, including a full set of x-rays or panorex taken within the past 5 years, and any and all checkup x-rays taken within the past 1 year, and request that they be transferred to:

Brittany VanBuskirk, DDS, PLLC  
5895 John R Road  
Troy, MI 48085  
Tel: (248) 828-8128

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Print Name of Patient

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Patient Signature

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Date