RECORDS RELEASE REQUEST

TODAY'S DATE: _____

TO: _____
(DOCTOR'S NAME)

ADDRESS: _____

CITY: _____STATE_____ ZIP_____

PHONE: _____ FAX:_____

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

LUMBERTON DENTAL CENTER, P.A.
KEVIN T. LAUGHLIN, D.D.S.
P. O. BOX 8239
LUMBERTON, TX 77657
(409) 755-4444
FAX (409) 755-3666
ldentalctr@gt.rr.com

_____ _____
PRINT NAME OF PATIENT SIGNATURE OF PATIENT, PARENT, OR GUARDIAN