# RECORDS RELEASE/REQUEST

To:________________________________________________

Address:______________________________________________

City:____________________ State:_______________ Zip:__________

I hereby authorize the release of my dental records or a copy of such and request that they be transferred to:

Office Name: Buffalo Dental Clinic

Office Address: 915 W Fetterman, Buffalo, WY 82834

Office Phone Number: 307-684-7533

Office Email: office@buffalodentalclinic.com

Date of records to be released:
From:__________________________ To:____________________________

Print Name of Patient:___________________________________________

Patient's Signature:______________________________ Date:___________

Please fax back to 307-684-8960