Bradley Crossfield, DDS
880 East Centerton Blvd.
Centerton, AR 72719
www.toothsquadpd.com

Request to Release Records

Patient Name: _____

Date of Birth: _____

Parent/Guardian's Name: _____

Phone Number: _____

I hereby authorize the release of dental/medical records, including but not limited to personal patient information, medical and dental histories, examination records, referral/consultation recommendations/reports, diagnostic models and any other related materials or copies of such:

Send Records to Doctor: _____

Office Email Address: _____

Phone Number: (_____) _____-- _____

Date Records are needed by: _____

Parent/Guardian Signature: _____

Date: _____