RECORDS RELEASE REQUEST FOR TREATMENT PURPOSES

Date_____

To_____
DOCTOR

Address_____

City_____ State_____ Zip_____

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

Berkeley Dental
Shun Hsu, DDS
General and Cosmetic Dentistry
1132 Athens Hwy., Suite 207 — Grayson, GA 30017
Telephone: (678) 512-0261

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

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