Parkway Dental

RECORDS RELEASE REQUEST

Date:______________________

To:____

Doctor/Physician

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 via email to:

parkwaydental@cableone.net

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Printed Name of Patient

____

Signature of Patient or Legal Guardian

Parkway Dental
208-342-4644
813 Stilson Rd Ste B
Boise, ID 83703