Dominguez Family Dental

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REQUEST FOR RELEASE OF HEALTH INFORMATION

I, _____ hereby grant permission to **Alexis Dominguez, DMD** to release information related to my health history, status, and treatment, and copies of my health record, x-rays, and any test results to:

_____

_____

_____

Phone number: _____

Patient Name (Please Print): _____

Signature of Patient/Guardian: _____

Patient's Phone Number: _____

Date: _____

Kindly provide a copy of a photo ID

Please allow our office 7 business days for all dental records to be ready