Records Release From

Date:____________________________

I hereby authorize Anderson Dental to release copies of my dental records and radiographs to:

Office Name:____

Address:____

City:______________________________ State:__________ Zip:__________________

Email address(es) to send records (records can be emailed to your new dental office and/or your personal email address)

____

Name of Patient (please print):____

Patient's Date of Birth: ____

Additional Family Member Under 18:____

Signature of Patient/Guardian (patient's 18 and older must sign their own release forms):

____

Phone: (217) 356-7334
Website: www.cusmiling.com
Email: info@cusmiling.com
Address: 2535 Galen Drive
Champaign, IL 61821