THANE B. ANDERSON DDS
Dentistry For Today's Family

Records Release Request

Patient Authority to Release Dental Records to Thane B Anderson DDS

Date: ____/____/____

I _____ (patient) hereby authorize

Dr. _____ (current dentist)

Of _____ (address)

_____

_____

Telephone: _____ Fax: _____

E-mail: _____

to release my dental records or copies thereof (including radiographs and photographs where applicable),

(if applicable) and those of my following dependents:

_____ DOB: ____/____/____

_____ DOB: ____/____/____

_____ DOB: ____/____/____

To:

Dr. Thane B Anderson DDS

1520 Vernon Street, Stoughton WI 53589

Phone: 608-873-3213 Fax: 608-873-7254 thaneandersonddsllc@yahoo.com

Patient/Parent/Guardian Signature:

_____ DOB: ____/____/____