REQUEST FOR RELEASE OF PATIENT RECORDS

George T. Christakos, DDS
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480-585-1795 Fax

Previous Dental Office Information:

Practice Name: _____

Practice Phone: _____

Practice Fax: _____

Practice Address: _____

Patient's Name: _____

DOB: _____

I, _____, authorize the release of my ***complete records including chart notes and copies of all x-rays.***

PLEASE SEND TO THE FOLLOWING TO: ***drchristakos@gmail.com*** ***or to the above listed address.***

Other Family Members:

_____*DOB*_____

_____*DOB*_____

_____*DOB*_____

_____*Date*_____

Patient or Parent/Guardian of minor