Dayton Dental Care
MICHAEL STRANG, DDS

Patient:
Guarantor:
Address:
Phone:
Patient DOB:

Please release medical and dental information for the above named patient, and those recorded below, to further their dental health.

Entity to receive this information is determined by patient/guarantor and is :

☐ Dayton Dental Care
1002 S 3rd Street
Dayton, WA 99328

☐ Personal Release

I hereby request:

to release all current medical and dental records (radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports) for the patient(s) named above to the checked entity. I expressly release from liability the above named person or entity from any and all liability arising from complying with this request and disclosure of the requested information. Thank you for your quick response.

Signed:_____

Date Signed: _____

1002 S 3rd Street, Suite 1, Dayton, WA 99328
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Facebook @ daytondentalcare