

Loving Family Dental
16930 East Palisades Blvd.
Suite 109
Fountain Hills, AZ 85268
Ph. 480.836.7600 Fax 480.836.1502
lovingfamilydental@hotmail.com

Consent for release of records from:

Dentist Name: _____

Address: _____

City: _____ **State:** _____

Zip code: _____

Phone: _____ **Fax:** _____

I, _____, consent to have copies of my dental records including notes, probings, and radiographs forwarded to

Loving Family Dental
16930 East Palisades Blvd.
Suite 109
Fountain Hills, AZ 85268

Patient name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Phone: _____

Signature: _____ **Date:** _____