SALLY C. POWELL | DDS

Please fill out this form and email it back to sally@sallypowelldds.com If you have any questions, contact us at 573-474-8566 and we would be happy to help.

RECORDS RELEASE REQUEST

Dentist or Name of Practice _____

Address _____

City _____ State _____ Zip Code _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request they be transferred to:

Dr. Sally C. Powell, DDS

2001 Corona Road – Suite 301
Columbia, MO 65203

sally@sallypowelldds.com

Name of patient(s) _____

Signature (patient, parent or guardian) _____

Date _____

I acknowledge that any dental warranty will expire when I cease regular appointments at this office.

Signature (patient, parent or guardian) _____