Ryan T. Anderson, D.D.S.

13 E. Fourth Street, LaJunta, CO. 81050 (719) 384-9442 ryan.andersonDDS3@gmail.com

DENTAL RECORD RELEASE AUTHORIZATION

TO: _____

Patient Name: _____
Date of Birth: _____
Additional Family Member Names and D.O.B.

_____ _____
_____ _____
_____ _____
_____ _____

I, the undersigned, hereby authorize Dental Records to be Released to:

Name: Dr. Ryan T. Anderson
Address: 13 E. 4th Street
La Junta, CO 81050
Phone: (719) 384-9442
EMAIL ADDRESS: **ryan.andersondds3@gmail.com**

The information supplied will be restricted to current x-rays, unless specifically requested

Purpose for which information is to be used:
_____Transfer of records to a different dentist
_____ Second Opinion
_____Other

Patient or Responsible party (for minor) signature

Date