S.A.H. D.M.D. Achieving Excellence in Dentistry

Records Release

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421 SW Bethany Dr.
Port St. Lucie, Fl. 34986
(772) 340-0805

Date: _____

Patient's Name: _____

Date of Birth: _____

Information Requested: _____

Request Information To Be Sent To: _____

_____

_____

I here by request that my medical records be released to the above doctor.

Signature of patient: _____

Signature of witness: _____

Confidentiality Clause

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