Dental Records Release Form

Patient Information

Name: ______________________________ **Date of Birth:** ________________

Authorizes: ____

To Release Records to: **Dr. Gregory J. Gorman DMD**

Send To: Gregory J. Gorman DMD

Address: 1301 N 7th St. Suite A Grand Junction, CO 81501

Phone: 970-242-9404

E-Mail: info@Ggormandmd.com

Information To Be Disclosed:

Treatment Plan & Radiology Films/ Images

Signature of Patient/Legal Guardian:

Sign: ____________________________________ **Date:** ____________________