Shelton DENTAL CENTER
1829 Jefferson Street - Shelton, WA 98584
Office 360-426-8401 - Fax 360-426-1427
Sheltondentalcenter@gmail.com

Records Release Form

I, (name) _____ request that my most current records be transferred to my new dental office.

From: _____ (dental office name)
_____ (dental office phone #)
_____ (dental office email)

To: _____ (dental office name)
_____ (dental office phone #)
_____ (dental office fax)
_____ (dental office email)

__ This request is just for me
__ This request is for myself and my family members (please list additional patients below):

_____
_____
_____
_____
_____

Signed:

_____ _____
Patient or guardian Date