



Dental Records Release

I _____, hereby request and authorize
_____, to disclose and provide copies of any and all clinical records including
but not limited to x-rays, perio charting and chart notes to the following:

BlueSky Dental
2500 West A Street Suite 204
Moscow ID 83843
info@blueskydentistry.com
208-882-9111 (Phone) 208-882-3279 (Fax)

(Please email x-rays and history, including all placement dates for crown, bridges, etc if possible)

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Patient signature

Patient name

Relationship to patient

Date

Patient address _____

Phone number _____

www.blueskydentistry.com

2500 West A St Suite 204 Moscow ID 83843

|

Office (208) 882-9111 Fax (208) 882-3279