



*"We Love To Help You Smile!"*

Dental Records Release

I \_\_\_\_\_, DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_, hereby request and authorize

**BlueSky Dental Phone: 208-882-9111**, email: [frontdesk@blueskydentistry.com](mailto:frontdesk@blueskydentistry.com) to disclose and provide copies of any

and all clinical records including but not limited to x-rays, perio charting and chart notes to :

Name of Dental Office \_\_\_\_\_, Phone \_\_\_\_\_

Email address \_\_\_\_\_.

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 \_\_\_\_\_

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