Michael W. Barton, D.D.S.
P.O. Box 399
Graeagle, CA 96103
530 836-2223
mwbartondds@psln.com

RECORDS RELEASE REQUEST

Date:___________

To:_______________________________________
(Doctor)

Address: _______________________________________

City:____________________State:_____Zip:_____

I authorize the release of dental records and x-rays relevant to dental treatment or copies of such. I also authorize the release of all relevant information, including my payment history. I request that they be transferred to:

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P.O. Box 399
Graeagle, CA 96103
530 836-2223
mwbartondds@psln.com

Date of Last:
Prophy
Exam
4 BWX
FMX/PANO (x-rays can be e-mailed)
Perio Chart

____
Print name of patient

____
Signature of patient