Wasilla
Phone: (907) 357-6684
Fax: (907) 357-6964
afd@akdental.com

Patients Name:_____Date of birth:_____

Phone number:_(_____)_____email:_____

Please print the names of any dependents:

_____

_____

_____

(Any patient over 18 must sign for their own release)

- ☐ I authorize my records to be sent **TO** Aesthetic Dentistry from:

  Name of Office:_____

  Office Fax:_(____)_____ Office Phone:_(____)_____

  Office Email:_____

- ☐ I authorize my records to be sent **FROM** Aesthetic Dentistry to:

  Name of Office:_____

  Office Fax:_(____)_____ Office Phone:_(____)_____

  Office Email:_____

I am requesting the release of the following for each patient:

1. _____All x-rays (By email)
2. _____All treatment notes (by Fax or email)
3. _____All periodontal charting (by Fax or email)

_____ _____/_____/_____

Patient Signature Date