REQUEST FOR RELEASE OF RECORDS

please detach form and return

I hereby request that my dental records be released to:

R. Boyd Gilleland, D.D.S. • 2496 Caring Way, Port Charlotte, Florida 33952

PREVIOUS DENTIST ______________________________

ADDRESS ______________________________

PATIENT'S NAME (PRINT) ______________ **PATIENT'S SIGNATURE** ______________

ADDRESS ______________ **CITY/STATE** ______________ **ZIP** ______

BIRTHDATE ______________ **SOCIAL SECURITY NO.** ______________

NAMES OF OTHER FAMILY MEMBERS TO BE TRANSFERRED ______________________________