MCKNIGHT

SIGNATURE DENTAL

RECORDS RELEASE/REQUEST

To Dr:_____

Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize the release of my dental records/x-rays or copies of such and request that they be transferred to:

McKnight Signature Dental
3400 College Blvd, Suite 203
Leawood, KS 66211
913-948-9710
info@mcknightsignaturedental.com

_____
Print Name of Patient

From:_____ To:_____
Date of Records

_____ _____
Patient's Signature Date