Date: ______________________
Time: ______________________
Initial: ______________________

**Please Email: office@twincreekdental.com*

DENTAL RELEASE FORM

Date: ______________________________

To: ______________________________

Address: ______________________________

____

Phone #: ______________________________

I authorize the release of my dental records to be transferred to

Twin Creek Dental
3811 Twin Creek Drive Suite 103
Bellevue, NE 68123
Phone # 402-715-5775 Fax # 402-502-0594

Patients Name Printed: __________________________ *Date of Birth:* ________________

Patients Signature: __________________________

*** Please release last BWX/Pano or FMX/last Perio Probes*