FLETCHER
FAMILY & COSMETIC DENTISTRY

Records Release Form

I,_____ , give my permission to Dr. John G. Fletcher, DMD, PLLC to release my dental records to one of the following:

- ☐ Another dental office
  - Name:_____
  - Address:_____
    _____
  - Telephone:_____
  - Fax:_____

- ☐ Myself
- ☐ Other _____
  _____

_____ _____

Patients Signature Date
(Or Parent of Child under 18)

Jgfdmdpllc5/08