RECORDS RELEASE REQUEST

Date_____

Bonnett Murphy Dental Associates

I, _____, request the release of my records. Please forward all necessary radiographs and notes to the following location:

To_____

Address _____

City _____ State _____ Zip _____

Reason for release:_____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

Richard Bonnett D.M.D.
Thomas Murphy D.M.D.
607 North Main Street
Butler, PA 16001
Phone: (724) 287-4468 fax: (724)287-3744

_____ _____

Print name of patient Signature (patient, parent, or guardian)