MEDICAL RECORDS RELEASE

Please fill out the following information if you would like our assistance in obtaining any dental records and/or radiographs from another dental/medical provider.

Doctor's Name: ____

Address: ____

Phone: ____

You are authorized to release my complete dental/medical records to:

Stone Ridge Dental
Dr. Matthew Smith
N14W23755 Stone Ridge Dr., Ste. 260
Waukesha, WI 53188
Phone: (262) 523-0220 Fax: (262) 523-0390
contactus@stoneridgedentalwi.com

Print Full Name: ____

Date of Birth: ______________________

Signature (Patient or Legal Guardian):______________________________

Date: __________________