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DENTAL RECORDS REQUEST FORM

Patient Name: _____Phone: _____

Releasing Doctor: _____
Address: _____
City, State, Zip: _____

Other Family Members: _____
_____
_____
_____

Please forward the most recent information that you have: x-rays, panolipse, probing depth chart notes, and photographs to the practice of Marcus A. Fairbanks, DDS and Darcy R. Galbraith, DDS, PLLC.

I hereby give you permission to release any and all of my records and/or any listed family members records included in this release to Marcus A. Fairbanks, DDS and Darcy R. Galbraith, DDS, PLLC.

Patient Signature (patients authorized representative) Date

If records are digital, please email to: info@fairbanks-galbraithdds.com

Or mail to: **Marcus A. Fairbanks/Darcy R. Galbraith, DDS**
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Bellingham, WA 98225