Record Release Request

Date:_____

Dr._____

Address:_____

City:_____ State:_____ Zip:_____

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:

Dr. Ashley L. Ulmer, D.D.S.
9708 N. Nevada, Suite 101
Spokane, WA 99218
(509) 468-3233

_____ _____

Print Patient Name & DOB Signature