BEACON
DENTAL CENTER
"Where our light shines on your smile."

Records Release Request

Patient Name: _____

Requesting Records From Dr.: _____

Please release all dental records to:

Dr. Michael A. Sullivan, DDS
Beacon Dental Center
06483 M-66 Highway North
Charlevoix, MI 49720
231.547.9141Phone
231.547.5077 Fax
smile@beacondentalcenter.com

I authorize the release of dental records and x-rays relevant to dental treatment.

_____ _____
Patient Signature Date