REQUEST FOR RELEASE OF RECORDS

To: _____
(Doctor/Hospital)

Address: _____

City: _____ **State:** _____ **Zip:** _____

I hereby authorize the release of my Clinical Records, X-rays and current Periodontal Charting or copies of such and request that they be transferred

To/From:
Eugene A. Covello, DDS
Matthew G. Verheul, DDS
Taylor M. Verheul, DDS
289 Main Street, Suite 100
Carbondale, CO 81623
Office: 970-963-3010
Fax: 970-963-4104
Email: drscandv@comcast.net

From: _____ **To:**_____
(Date of Records)

Patient Name: _____ **Date of Birth** _____

Patient Signature_____ **Date** _____