



FLETCHER
FAMILY & COSMETIC DENTISTRY

Records Release Form

I, _____, give my permission to Dr. John G. Fletcher, DMD, PLLC to release my dental records to one of the following:

☐ Another dental office

- Name: _____
- Address: _____

- Telephone: _____
- Fax: _____

☐ Myself

- ☐ Other _____

Patients Signature
(Or Parent of Child under 18)

Date