Dental Records Release

Kalispell Family Dental

720 2nd St. E.
Kalispell, MT 59901
kalispellfamilydental@gmail.com
406-755-4766

I, (print patient or guardian name), _____, hereby authorize the doctor and staff of_____, to release records or knowledge concerning my dental health:

1. Given directly to me
2. Sent directly to a dental office

   Email: _____

3. Given to a guardian (if patient is a minor)

I am requesting that you release the following (check 1 or both):

1. All x-rays
2. All treatment notes

Signature of patient or guardian.