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## RECORDS RELEASE FORM

Date of request: \_\_\_\_\_

Please release current x-rays and records for: (Patient name/ Date of birth)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Previous office information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please send records to (office): \_\_\_\_\_

\_\_\_\_\_

Please have records ready by: \_\_\_\_\_

Patient Signature: \_\_\_\_\_