<u>Records Release Request</u>

Date: _______________

Robert L. Martinich, D.M.D., P.C.
YOUR Highlands Ranch DENTIST

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

To: ____
Doctor/ Physician

Address: ____

City: __________________________________ State: ________ Zip: _______________

Phone: _________________________________ Fax:____________________________

Email: ____

____
Print Name of Patient Date of Birth

____
Signature (patient, parent, guardian)