Jones Cosmetic & Family Dentistry

Records Release/Request

TO: _____
Doctor/Hospital

Address: _____

City/State: _____ Zip:_____

I hereby authorized the release of my dental records and x-rays and request that they be transferred to:

Jones Cosmetic & Family Dentistry
Deborah W. Jones, D.D.S., P.C.
1509 Robinson Road
Old Hickory, TN 37138—2811
PH: (615) 847-3530
FAX: (615) 847-4665

_____
Print name of Patient

From:_____ To:_____
Date of Records

_____ _____
Patient's/Guarantor's Signature Date