1829 Jefferson Street - Shelton, WA 98584
Office 360-426-8401 - Fax 360-426-1427
Sheltondentalcenter@gmail.com

Records Release Form

I, (name) ______________________________ request that my most current records be transferred to my new dental office.

From: ______________________________ (dental office name)
______________________________ (dental office phone #)
______________________________ (dental office email)

To: ______________________________ (dental office name)
______________________________ (dental office phone #)
______________________________ (dental office fax)
______________________________ (dental office email)

__ This request is just for me
__ This request is for myself and my family members (please list additional patients below):

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____
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Signed:

______________________________ ______________________________
Patient or guardian Date