Records Release/Request

To		
	(Doctor/Hospital)	
Address		
City	State	Zip
I hereby aut	horize the release of m	y:
X-rays	Perio Charting	Full Dental Records
or copies of	such and request that t	hey be transferred to:
	Cherry Lane Dental John Bergloff, D.D.S. 1104 W. Cherry Lane Meridian, ID 83642 Telephone: (208)888-7889	
Print Name of	Patient	· · · · · · · · · · · · · · · · · · ·
Patient's Signature		Date