NOWLIN DENTAL CLINIC
201 GARRETT, ELK CITY, OK 73644
(580) 225-4690
nowlindental@gmail.com

REQUEST FOR RELEASE OF MEDICAL/DENTAL RECORDS

TO: _____

I authorize the release of all medical/dental records, health history, & x-rays for: _____, Date of Birth: _____, which are to be sent to **NOWLIN DENTAL CLINIC.**

Please send **(BY EMAIL IF POSSIBLE):**

__X___ ALL TREATMENT NOTES
__X___ ALL X-RAYS
__X___ ANY TREATMENT PLAN

Please send treatment notes even if x-rays are not sent.

_____, Patient or Parent if under 18.

PLEASE EMAIL RECORDS TO:

nowlindental@gmail.com