Records Release Request

Date: _________

TO: ___________________________________
Doctor/Physician

Address: ____
City: _________________________________State: _________Zip__________
Phone: ________________________Fax:____________________

I authorize the release of dental treatment, x-rays, or copies of such and request that they be transferred to:

Magnolia Family Dentistry, LLC
Dr. Patricia J. Fast, DMD
1507 A Heritage Lane
Florence, S.C. 29505
Telephone: (843) 665-4477
Fax: (843) 629-0880

____ ____________________
Print name of patient **Date of Birth**

____
Signature (patient, parent, guardian)