STUART PROSTHETIC
DENTISTRY

## RECORD RELEASE

I, _____ request a copy of my medical and dental records, including radiographs, be released and forwarded to:

Stuart Prosthetic Dentistry
1001 East Ocean Blvd.
Suite 102
Stuart, FL 34996
(772) 286-1606
**info@stuartpro.com**

X _____ Date _____
Signature of patient, parent or guardian

## PATIENT INFORMATION

Patient's Name: _____ Guardian (if under 18): _____ DOB: _____

Address: _____ City_____ State_____ Zip_____

Thank you for your cooperation in this matter,

X _____ Date _____

Olin D. Tyler II, CDT, DMD, MS, PA