RELEASE OF RECORDS

I am requesting that my records be sent to:

Mark T. Albers, DDS
2155 Hollow Brook Dr., Ste 20
Colorado Springs, CO 80917

Please send the following items:

____Full Mouth or Pano X-rays if taken within the past five years

____Bite-Wing X-rays within one year

____Most recent Perio Charting

If you have the x-rays on digital you can email them to:

dralbers@albersdental.com

Reason for release____

Patient Name (please print)____

Signature____

Date of Request___________________________