Swankhouse Dental

Barbara D. Swankhouse, D.D.S. General Dentistry
Phone: (303) 935-6559

Authorization to Release Dental Records and X-Rays

Patient Name:
_____
Previous Name:
_____
Date of Birth: _____ SSN: _____
Address: _____ City: _____
State: _____ Zip: _____
Practice Name: _____ Doctor's Name: _____

Additional family members:
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____

I, (patient or guardian name) _____, hereby authorize the release of dental records, healthcare information and radiographs of the patients listed above. I request that these records be transferred to Dr. Barbara D. Swankhouse at the below address. Secure email is the preferred option.

Signed (patient or guardian name): _____ Date: _____

info@swankhousedental.com **Fax: (303) 935-5408**

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