Trevor L. Denny, D.D.S.
1809 Cliff Drive, Suite C
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Tel. 805.963.3210
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REQUEST FOR DENTAL RECORDS

TO:_____

ADDRESS:_____

_____

This is your authorization to release copies of all current information from my medical or dental file, including radiographs to Dr. Trevor L. Denny.

Patient's Name(s):_____

_____

Patient's Date of Birth:_____

Signature:_____

Date:_____

Please e-mail digital records to **drtrevor@denny.sbcoxmail.com**

If you have any questions feel free to call 805.963.3210