SCOTT HERRE
DENTISTRY

INTEGRITY, CARE, EXCELLENCE

RECORDS RELEASE REQUEST

DATE_____

TO (DOCTOR OR HOSPITAL)_____

ADDRESS_____

CITY_____STATE_____ZIP_____

I hereby authorize the release of my _____ or copies of such and request that they be transferred to:

Scott B. Herre, D.D.S.

11237 Nall Avenue, Suite 140

Leawood, Kansas 66211

Email: info@scottherredentistry.com

Fax: 913-912-7343

PRINT Name of Patient_____

FROM_____ TO _____

(Date of Records)

SIGNATURE OF PATIENT _____