Dr. Whitney Frank DDS
801 E Medical CT
Post Falls, ID 83854
TEL: (208) 773-1559

REQUEST FOR RELEASE OF DENTAL RECORDS

Name: _____
Address: _____
Telephone: _____

I hereby request the following dental records be released:
___ Complete records and x rays
___ Partial records and x-rays
___ Previous 5 years
___ Specific information and x-rays:

Please send the above request to:

Name: _____
Address: _____
Telephone: _____

_____ _____
(Patient's Signature) (Date)

*A written request from the patient is required in accordance with Idaho State Law.