

Loving Family Dental  
16930 East Palisades Blvd.  
Suite 109  
Fountain Hills, AZ 85268  
Ph. 480.836.7600 Fax 480.836.1502  
lovingfamilydental@hotmail.com

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Consent for release of records from:

Dentist Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I, \_\_\_\_\_, consent to have copies of my dental records including notes, probings, and radiographs forwarded to

**Loving Family Dental**  
**16930 East Palisades Blvd.**  
**Suite 109**  
**Fountain Hills, AZ 85268**

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*This form may be faxed or mailed to a former dentist so they may release records to our practice.*