CHRISTINA P. MILLS, DDS

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REQUEST TO RELEASE MEDICAL RECORDS

Patient's Name _____ Date _____

Date of Birth _____

Please release my medical records (circle To or From and fill in other DDS info):

To From To From

Christina Mills, DDS _____

1701 Sunset Lane _____

Culpeper, Va 22701 _____

E-Mail _____

Permanent transfer? (circle one) Yes No

Reason for transfer _____

_____

_____ _____

Patient/Legal Representative Signature Date

_____ _____

Witness Signature Date

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OFFICE USE ONLY:

Approved by Dr. Mills _____ Date sent _____