FOREST DRIVE
DENTAL CARE

Records Release Form

To:_____
Phone/Fax:_____
Street:_____
City/State/Zip:_____
Email:_____

Patient Name(s):_____

Street:_____

City/State/Zip:_____

Please accept my signature below as authorization to release all dental records including x-rays, charting and photographs for the patient(s) listed above to:

Forest Drive Dental Care, P.A.
Dr. Joanna S. Dover
Dr. Sarah Anne Knowlton
3731 Forest Drive
Columbia, SC 29204
(p) 803.782.8786 (f) 803.782.6682
office@forestdrivedental.com

Patient/Guardian/Representative Signature:_____
Relationship to patient:_____
Date:_____