I, _____ AUTHORIZE THE RELEASE OF ANY AND ALL DENTAL AND MEDICAL RECORDS TO PARKVIEW DENTISTRY, DR. VERNE WILLARD. PLEASE DUPLICATE RADIOGRAPHS AND PERIODONTAL CHARTING WOULD BE GREATLY APPRECIATED. THANK YOU.

DENTIST NAME_____

ADDRESS_____

PHONE_____ FAX_____

MAIL TO:

PARKVIEW DENTISTRY

13014 N. SAGUARO BLVD SUITE 203

FOUNTAIN HILLS, AZ 85268

EMAIL: drverne@fountainhillsdentist.com