RECORDS RELEASE REQUEST

Doctor's Name: ______________________________________

Address:____

Phone Number: ______________________________________

Fax Number: ____

I authorize the release of my dental records to:

Peter L. Thompson, D.D.S.

123 West 2nd St

Portales, NM 88130

Phone: (575)359-1011

Fax: (575)356-2947

Please email x-rays to: kristysmiles@yucca.net

Name: ____

Signature: ____

Date: ____