



Date: \_\_\_\_\_

To: \_\_\_\_\_  
*Doctor/Office*

I am writing to authorize the release of my dental records to the office of MARCH DENTAL CARE. Such records include, but are not limited to, patient forms, chart notes, radiographs, patient photographs, specialist correspondence and outside records.

Please provide these records to:

MARCH DENTAL CARE  
1502 St Marks Pl suite 7  
Stockton, CA 95207  
209 957 8776  
marchdentalcare@gmail.com

Sincerely,

Sign: \_\_\_\_\_

Print: \_\_\_\_\_