Brandon W. Romick, D.M.D. & Associates

Record Release Request

Date:_____

Patient's Name: _____

Date of Birth: _____

Signature: _____

If patient is a minor, relationship to patient: _____

I request and authorize the release of dental records and x-rays relevant to dental treatment, or copies of such, and request they be transferred to:

To: _____

Address: _____

City: _____ State/Zip: _____

6270 River's Bend Drive, Maineville Ohio 45039 Ph: 513.494.0333 Fax: 513.494.0222