

**RECORDS RELEASE/REQUEST**

To Dr: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release of my dental records/x-rays  
or copies of such and request that they be transferred to:

Schutte and McKnight Dentistry  
3400 College Blvd, Suite 203  
Leawood, KS 66211  
913-948-9710  
beth@schuttemcknightdds.com

\_\_\_\_\_  
Print Name of Patient

From: \_\_\_\_\_ To: \_\_\_\_\_

Date of Records

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date