

Dental Records Release Form

First Name

-

Last Name

-

Authorizes to disclose to:

Self

Dental Provider

Name of the Dental Provider:

-

Form of delivery

Mail

Email

Fax

Send to: Ovation Dental

7700 Madison Street

River Forest IL 60305

Phone 708-689-0419

Fax 708-689-0687

Email: contactus@villaridds.com

Information to be Disclosed: Treatment plan x-rays All Billing Records

E-Signature (draw, upload or type) (ESign)

Date

-

Date :