

# Release of Dental Records

Records requested from: Dr. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, request that your practice forward my current dental films and chart notes to the following address:

**Dr. Kevin M. Easley, DMD, PC  
3003 Minnesota Drive Suite 200  
Anchorage, AK 99503  
(907)248-0022  
(907)677-2552 FAX**

Additional family members to be included:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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