Records Release Form

Please release the radiographs (x-rays) and dental records of:

Name(s): _____ Birth date: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

To: Third Ward Dental
219 N. Milwaukee Street
Fifth Floor
Milwaukee, WI 53202

Electronic records may be e-mailed to: records@ThirdWardDental.com

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature Date

Signature of all patients over the age of 18 is required.