

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

Date