TIM OWENS DDS
DENTISTRY

Authorization to Release Dental Information

Patient Name: _____

Date of Birth: _____

Release To: Timothy M. Owens, DDS
3506 Lochwood Drive
Fort Collins, CO 80525

Phone: 970-377-2557
Fax: 970-377-0761

If x-rays are digital, please email to info@owensdds.com

Information requested:

___Copy of Dental Chart ___Copy of Dental x-rays ___Other_____

Patient Signature_____ Date_____

Authorized Staff Signature_____ Date_____

Information of previous DDS:

Name of Doctor_____

Phone # _____

Fax # _____

Address_____

Email Address_____