17167 E. Cedar Gulch Parkway, Suite 202
Parker, Colorado 80134
303-805-9999
FAX 720-500-6076
WEBSITE www.evansondds.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

Dental Office:_____
Address_____
_____
Phone:_____
Email:_____
Fax:_____

I,_____
(Print Name) (Date of Birth)

Authorize and request my dental records/x-rays to be released to:

Angela Evanson, DDS
17167 E. Cedar Gulch Pkwy.
Suite 202
Parker, CO 80134
Fax: 720-500-6076

You may email digital records to: **info@evansondds.com**

_____
(Patient/Guardian Signature)