Forest Hills Dental
4500 Cascade Rd SE Suite 107
Grand Rapids, MI 49546
officedrsal@gmail.com
616-957-1304

Records Release Request

Date:_____

I hereby authorize the release of dental records or copies of such, for the following patient(s):

_____
(Print Patients name)

_____

_____
(Print names of additional family members)

_____ _____
(Patients signature) (Date)

_____ _____
(Family member signature-unless minor) (Date)

Transferred to:

_____
(Doctor's Office Name)

_____
(Address)

_____
(City, State, and Zip Code)

Email address:_____
(Doctor's Office Email Address)

Reason For Leaving:

_____

_____

_____

**By signing this I acknowledge that I release the office of Dr. Mark L. Salhaney, DDS from any laws related to the disclosure of confidential or privileged information.