AM

Arthur B. Montoya, Jr., D.D.S.

general and cosmetic dentistry

RELEASE OF DENTAL RECORDS

I hereby request that a complete copy of _____ DOB_____
(Patient's Name)

dental records, including any previous dental x-rays, be sent to:

Art Montoya

2610 Trinity Dr Suite 3

Los Alamos, NM 87544

Fax #:505-661-0225

Records From (Dentist):

Previous Dentist's Name:_____

Address: _____ Phone number: _____

Email: _____ Fax number: _____

☐ I give my permission for my records to be sent electronically, i.e. faxed and/or emailed.

Please send digital records to **abmsmiledr1@aol.com**

Thank you for your cooperation in this matter.

Printed Name: _____

Signature: _____

Date: _____