COLE
FAMILY DENTISTRY

JEFFREY A. COLE, D.M.D. SUSAN G. COLE, D.M.D. DIANA E. SHOE, D.D.S.

I _____hereby request a copy of my dental records as detailed below.

- **I also request copies of my family's dental records.**

Family Members: _____

_____

Records to be transferred to:

Dentist Office: _____

_____

_____

Reason for leaving: _____

Patient Name: _____

Relationship to Patient: _____

Signature of Patient/Guardian: _____

Date: _____

*By signing the above release form, the patient agrees to forfeit their warranty on ANY Cerec restorations completed by Dr. Jeffrey or Susan Cole.

Office Use Only: Date records released: _____ Initials: _____