Williams ORTHODONTICS
Your smile is our specialty

# *Request for Release of Records*

I hereby request and give permission to _____
to provide Williams Orthodontics all orthodontic records for
_____(Patient's Name/D.O.B.).
Such records may include; x-rays, study models, photos and copies of all other dental records you may have.

I understand there may be a fee to duplicate any records. A photocopy of this release will be as effective and valid as original.

Signed: _____
(Patient, Parent, or Legal Guardian if under 18 years old)

Date Signed: _____

Photos and x-rays can be emailed to:
info@williamsorthodontics.net attn: Michelle.

Please mail study models to:
Williams Orthodontics
32045 Castle Court, #200
Evergreen, CO 80439