Dear Dr. ____________________________________,

Please release any information in my records relating to my diagnosis and treatment history to:

Joseph R. Gatti, D.D.S.
5100 Bob Billings Pkwy Ste 110
Lawrence, KS 66049
(785) 749-2943
(785) 749-0929 fax
www.gattidds.com
gattidds@gattidds.com

____ ____________________
(Printed Name) (DOB)

____
(Address)

____ ____________________
(Signature) (Date of Signature)

Please send the following either thru mail, fax or email:

Dental Records ☐ Panoramic X-ray ☐ BW X-ray

Medical Records ☐ Polysomnography - Study Summary & Interpretation Pages

Comments:

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