Dear Dr._____

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

Lawrence Dental Studio
5100 Bob Billings Pkwy Ste 110
Lawrence, KS 66049
PH: (785) 749-2943
FAX: (785) 749-0929 fax
www.lawrencedentalstudio.com

team@lawrencedentalstudio.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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