



JEFFREY A. 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 Cole Family Dentistry.

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Office Use Only:      Date records released: \_\_\_\_\_      Initials: \_\_\_\_\_