**Ardente Dental, PSC**
**1009 S. Jackson Street**
**Frankfort, In. 46041**
**765-654-7222**

# RELEASE OF RECORDS FORM

Patient Name:_____
Date:_____

I hear by request the release of my current radiographs from Ardente Dental, PSC to _____ .

I understand that specific treatment has been recommended which I am declining to have performed in this office. These may include any of the following which are circled below.

Restorations ( fillings )
Root Canal Therapy
Periodontal Treatment
Preventative Therapy
Oral Surgery
Other _____.

**I agree to the termination of the Doctor- Patient relationship. I also understand that should I choose to return at a later time for treatment I will be able to do so.**

Signature of Patient _____

Witness_____