

**Request For Release Of Records**

**Patient:** Please complete this top section. List health care providers who have records related to your current problem. We will forward this request to the providers on your behalf.

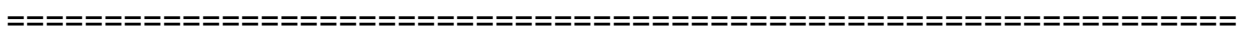
Providers:

Date of request: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient, parent, or guardian signature: \_\_\_\_\_

Brief Description of your Chief Complaint:



**Dear Health Care Provider,**

Please release copies of requested records related to the Chief Complaint listed above to Santa Fe TMJ. Instead of records, a report about this chief complaint will be useful if you prefer.

**Please send records or a report to:**

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Santa Fe Center For Dental Medicine  
2019 Galisteo St, Bldg J2  
Santa Fe, NM 87505  
phone: 505-474-4644 • fax: 877-748-9260 • email: office@wartell.com

Thank you very much.

Pat Wartell, Patient Care Coordinator