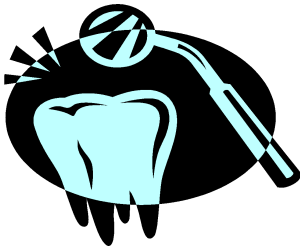

Dr. Michael A. Lamp, DDS, PA
4511 Sun N Lake Blvd., Suite 102
Sebring, FL 33872
Phone: 863-385-1911
Fax: 863-385-2869

REQUEST FOR RELEASE OF DENTAL RECORDS

To: (Previous dentist) _____

(Address)_____

(Phone and/or fax#)_____

Re: (Patient name)_____

Date of Birth: _____

Dear Dr. _____

I request that my dental records, including any X-rays be released and sent to:

Dr. Michael A. Lamp, DDS

Please send to the above physical address or email to info@lampdds.com.

_____ _____
Patient's Signature Date