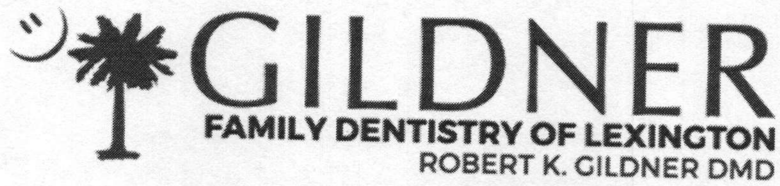


Dental Record Release Form

Date: ____________________

I now authorize the release of my dental records or copies of such. I request that they be transferred to

Office Name: ______________________________________

Address: ______________________________________

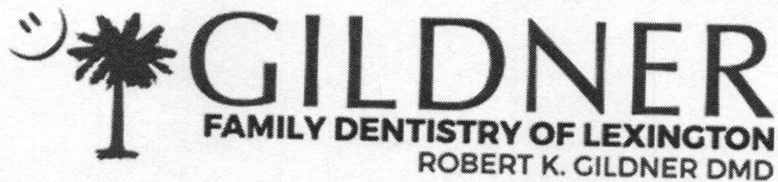
Email: ______________________________________

From: ______________________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Patient Signature: __________________________________



602 E Main St Suite E

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