

Dental Records Release Form

Patient Name: _____

Date of Birth: _____

Phone number: _____

Current Dentist: _____

Address: _____

Phone number: _____

Please forward any of the following information that you have: patient notes, x rays, charting, intra oral photos to

New Dentist: _____

I hereby give you permission to release any Dental records to the above Dentist.

Patient Signature: _____

Date: _____