DENTAL RECORDS RELEASE FORM

| Patient Name: | | | |
|------------------------------------|--------|---------|-------|
| | | | |
| Address: | | | |
| (Street) | (City) | (State) | (Zip) |
| Home Phone: | | | |
| Work Phone: | | | |
| Birth Date : | | | |
| Please transfer my dental records: | | | |
| From: | To: | | |
| | | | |
| Patient Signature: | | | |
| Date: | | | |
| | | | |

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