



Records Release

Patient Name: _____ Date of Birth: _____

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

(OLD OFFICE) I authorize the following clinic to release my records, including Any and all requested dental information, including copies or Photostats of my dental record and radiographs, concerning treatment given to me at:

Dentist/Clinic Name: _____

Phone Number: _____

City/State/Zip: _____

Email: _____

Reason for Leaving:

Moving Insurance is out of network Hours of Operation Billing Problem

Other (Please specify): _____

(NEW OFFICE) I am requesting my records be sent to:

Dentist/Clinic Name: _____

Phone Number: _____

City/State/Zip: _____

Email: _____

**Signature of Patient, Parent
or Guardian (if under 18)**

Today's Date