McCracken Family Dentistry

3801 Market Street Camp Hill, PA 17011
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Mark K. McCracken D.M.D. Kirk W. McCracken D.M.D.

DENTAL RECORDS RELEASE FORM

Patient Name to transfer: _____

Date of birth: _____ Phone number: _____

Other family members to transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

City, State, Zip: _____

Phone number: _____ Fax number: _____

Please forward any of the following information that you have: recent x-rays, probing depth chart and photographs to McCracken Family Dentistry.

I hereby give permission to release any and all of my dental records to McCracken Family Dentistry.

_____ _____
Patient Signature (parent, if a minor) Date

If records are digital, please email to:
smile1@mccrackenfamilydentistry.com

or mail to:
McCracken Family Dentistry
3801 Market Street
Camp Hill, PA 17011