McCracken Family Dentistry

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DENTAL RECORDS RELEASE FORM

Patient Name to transfer: ____

Date of birth: __________________ Phone number: __________________

Other family members to transfer: ____

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

Dentist or Practice Name: ____

Address: ____

City, State, Zip: ____

Phone Number: __________________________

Email Address: __________________________

I hereby give permission to release any and all of my dental records to:

____ (Dentist or Practice Name)

________________________________ ________________________________

Patient Signature (parent, if a minor) Date

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