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DENTAL RECORDS RELEASE FORM

I consent to the release of a copy of the dental records of the patient listed below, to include all radiographs and any information requested by the patient, to be sent to the new dental office listed below or to be picked up by me.

Patient's Name _____Birthdate_____/_____/_____

Patient's Address _____

Patient's Social Security Number _____

☐ I will pick up records on _____/_____/_____

☐ Please send records to : Dr _____

Address:_____

Phone: _____

To help us improve our service please tell us why you are leaving our practice:

_____

_____

_____

Printed Name of Patient: _____

Responsible Party Signature_____Date_____/_____/_____