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/ St. Zip: _____

Phone Number: _____

Please forward any of the following information that you have: X-Rays, Probing Depths, Chart, Charting, and Photographs to: sharonwells.elktonbeardental@gmail.com

I hereby give you permission to release any and all of my dental records to Elkton- Bear Dental Arts.

_____ _____

Patient Signature (Guardian if minor) Date

Please mail to:

Elkton-Bear Dental Arts

142 West High Street

Elkton, MD 21921