REQUEST FOR RELEASE OF PATIENT RECORDS

Patient's Name: ____ **DOB**: ______________________

Additional Family Members (if necessary):

Name: **DOB:**

____ __________________________
____ __________________________
____ __________________________
____ __________________________

Previous Dentist Name: ____

City/State: ____

Phone: ____

Fax: ____

I authorize the release of my dental and medical information to Brenner Family Dental (bitewings within 24 months, panoramic and/or full mouth series within 5 years).

Signature: ____**DATE**: ____________________

(of Patient, Parent or Guardian)

*****Please send digital x-rays to:*****

info@brennerfamilydental.com

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