Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____

Other family members to transfer: _____

_____

Please release dental records for the patient listed above to the following Dental/Medical Office (please include email address and/or mailing address):

_____

_____

I hereby give Texas Pediatric Dentistry permission to release all dental records, including x-rays, charting, and photographs to the dental/medical provider listed above.

Parent/Guardian Signature: _____

Date: _____

After signing and dating this form, you can bring it by our office, fax it to us, or scan and email it.

Address: 3595 S. Custer Rd. Suite 100
McKinney, TX 75070

Fax: 972.542.6691

Email: info@TexasPediatricDentistry.com