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: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

INFORMATION REQUESTED:
☐Copy of complete dental chart

☐Copy of dental x-rays

☐Other (models, etc. – provide details)

DATES COVERED:
☐All treatment rendered in previous office

☐Limited to treatment dates and for conditions described below

_____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:
☐Transfer of records

☐Referral (oral surgeon, orthodontist, endodontist, etc.)

☐Other

_____

I hereby give you permission to release any and all of my dental records to Carbondale Family Dental.

Patient/guardian signature: _____ Date: _____

Guardian name: _____

If records are digital, please email to: info@carbondalefamilydental.com
Or fax/mail to:
Carbondale Family Dental
889 Main Court
Carbondale, CO 81623
Phone: 970-963-1616
Fax: 844-602-4638