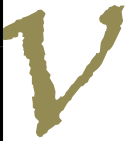

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RECORDS RELEASE FORM

I, ________________________________authorize release of my dental records from
(PATIENT NAME)

Previous Dentist name/Office name: ____
Address: ____
Phone number: ____
Email address: ____

Please email most recent X-rays, preferably most recent FMX and bitewings to:
info@vanormandental.com

Print Name: ____DOB____________________

Signature:____

Date:____

Thank You