RELEASE OF DENTAL RECORDS

Previous Dentist: _____

Address: _____

Telephone: _____ Fax: _____

Email: _____

I hereby request the release of all dental records including radiographs and daily treatment notes to be forwarded to:

ADVANCED DENTISTRY

435 Highland Avenue Suite 210
Cheshire, CT. 06410
(203)272-7271
Fax (203)272-8882
office@addentistry.com

☐Dexis ☐JPEG

**** (Please e-mail individual films with dates)**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient/Guardian Signature: _____Date: _____

For Office Use Only:

Date release form was faxed: _____ Staff Initials: _____

Notes: (if you spoke to someone at previous office-what hx do they have?)

_____

_____