MIDDLETOWN
FAMILY DENTISTRY

REQUEST OF DENTAL RECORDS

(This form is to be completed by you and sent to your previous dentist so that your dental records can be sent to our office)

Dear Dr. _____, please release all dental records/records including radiographs and perio charting of the following patient/patients. He/she has recently transferred to our practice.

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

RELEASE AUTHORIZATION

I authorize the office of _____/_____
Previous Dentist Phone Number

_____ / _____
Previous Dentist Email Address Fax Number

To release the above records, including information, records and/or radiographs to the office of Middletown Family Dentistry. The records can be forwarded electronically to the email address: xraysmfd@middletownfamilydentistry.com or mailed to the address below. Thank you.

_____ _____
Patient/Guardian Signature Date

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302.376.9159
Fax 302.376.1947