MIDDLETOWN
FAMILY DENTISTRY

TRANSFER OF DENTAL RECORDS

This is to request and authorize Middletown Family Dentistry to release and provide copies of the following records and/or radiographs concerning dental care that was provided for the following:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

_____
Name of New Dentist

_____
Street Address City State Zip

_____ _____ _____
Email Address Telephone Fax

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information. Dentistry is our Profession but people are our focus. As we continually strive to improve: please assist us by stating the reason for leaving our practice. Your comments are much appreciated

_____
_____
_____

_____
Patient/Guardian Signature Date

Lauvic Professional Building
122 Sandhill Drive, Suite 101
Middletown, Delaware 19709
www.middletownfamilydentistry.com
302.376.9159
Fax 302.376.1947