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/St/Zip: _____

Phone Number: _____

Fax Number: _____

Email: _____

Please forward any of the following information that you have: x-rays, probing depth chart, chart notes, and photographs to Premier Dental Wellness.

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

_____ _____

Patient Signature (parent if a minor) **Date**

If records are digital, please email to:

marzdds@gmail.com

Or mail to:

Richard F. Marz, DDS
Alexander Y. Brown, DMD
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Statesboro, GA 30458
(912) 764-3724