901 Dehirsch Ave Woodbine, NJ 08270
Phone (609) 861-2784
Fax (609) 861-3160
woodbinedental@aol.com

Records Release Form

Name of Patient Whose Dental Record is Requested: _____

DOB: _____ **PHONE**: _____

PLEASE PROVIDE A COPY OF THE DENTAL RECORD AS INDICATED BELOW:

_____ **Bitewing X-rays (if less than 1 year old)**

_____ **Full mouth or Pano X-ray if less than 3 years old)**

_____ **Other:** _____

PLEASE FORWARD MY REQUESTED DENTAL INFORMATION TO:

Name of New Dentist:_____

Address of Dentist:_____

City/State/Zip:_____

Office Phone:_____

Email:_____

***I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release of the above requested information.**

_____

Signature of patient or patient's authorized representative **Date signed**

_____

Relationship or status if signed by anyone other than patient (parent, legal guardian, etc.)