
FAMILY DENTAL CARE

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# Dental Record Release Form

**Patient(s) Info:**
Patent Name(s): _____

Address: _____

City:_____ State:_____ Zip/Postal Code: _____

Phone: _____ Email: _____

I hereby authorize the release of my records for myself and family members. Please include all recent radiographs, chart notes, and periodontal charting.

**From:**
Dentist/Company Name: _____

Address: _____

City:_____ State:_____ Zip/Postal Code: _____

Phone: _____ Fax: _____Email: _____

**To:**
Dentist/Company Name: _____

Address: _____

City:_____ State:_____ Zip/Postal Code: _____

Phone: _____ Fax: _____Email: _____

Patient Signature: _____ Date: _____

Form Valid Through: _____

***Please Note:*** *All patients over the age of 18 must sign their own forms. Only a parent or legal guardian may sign for a patient under the age of 18.*