Skyline
FAMILY DENTISTRY
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DENTAL RECORDS RELEASE FORM

Patient name: _____

Date of Birth: _____Phone Number: _____

Members of family: _____

_____

Previous dentist or practice name: _____

Address: _____

Phone number: _____

Please forward my dental records (X-rays, perio charting and notes) to Skyline Family Dentistry. Digital Images can be emailed to skylinereceptionist16@gmail.com

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

_____ _____

Patient's Signature Date