Dental Records Release Form

Patient Name to transfer: First: _____ Last: _____

Date of Birth: _____ Phone number: _____

Other Family members to transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

City/St/Zip: _____

Phone number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Birch Family Dentistry.

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

_____ _____

Patient Signature (parent if a minor) Date

If records are digital, please email to: birchfamilydentistrywy@gmail.com

Or mail to:

Birch Family Dentistry

661 Uinta Drive

PO Box 309

Green River, WY 82935