Dental Records Release Form

Patient Name to transfer: _____

Date of Birth: _____

Other family members to transfer:

_____

_____

_____

Please release dental records for the patient listed above to the following Dental/Medical Office (please include email address, together with, phone number and mailing address):

_____

_____

_____

_____

I hereby give **Texas Pediatric Dentistry/Stonebridge Ranch Dentistry** permission to release all dental records, including x-rays, charting, and photographs to the dental/medical provider listed above

Parent/Guardian Signature: _____ Date: _____

Please return this form via mail, fax or email to:

Texas Pediatric Dentistry
3595 S. Custer Rd. Suite 100
McKinney, TX 75070
972-542-6662
Fax: 972-542-6691
info@texaspediatricdentistry.com

Stonebridge Ranch Dentistry
3575 Lakota Trail, Suite 100
McKinney, TX 75070
972-542-1212
Fax: 972-542-6691
info@stonebridgeranchdentistry.com