

# Dental Records Release Form

Patient Name to transfer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other family members to transfer:

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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):

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I hereby give **Texas Pediatric Dentistry/Stonebridge Ranch Dentistry/TPD Smiles** 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  
Phone: 972-542-6662  
Fax: 972-542-6691  
[info@texaspediatricdentistry.com](mailto:info@texaspediatricdentistry.com)

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

TPD Smiles  
3575 Lakota Trail, Suite 100  
McKinney, TX 75070  
Phone: 469-907-1080  
Fax: 972-542-6691  
[info@tpdsmiles.com](mailto:info@tpdsmiles.com)