Records Release Form

I _____hereby request a copy of my dental records as detailed below.

☐ I also request copies of my family's dental records.

Family Members:

_____

_____

_____

_____

_____

Records to be transferred to:

Dentist Office: _____

Address: _____

Email: _____

Reason for leaving: _____

Patient Name: _____

Relationship to Patient: _____

Signature of Patient/Guardian: _____

Date: _____

*By signing the above release form, the patient agrees to forfeit their warranty on ANY Cerec restorations completed by Family Smiles Dentistry & Facial 32 Dental Esthetics.

_____

Office Use Only:

Date records released: _____ Initials: _____