



RELEASE OF RECORDS AUTHORIZATION

| DOB:

Please select which scenario applies to you	
What is your previous dentist's name/practice name?	
What is your previous dentist's address?	
What is your previous dentist's phone number?	
What is your previous dentist's email address?	
What is your new dentist's name/practice name?	
What is your new dentist's address?	
What is your new dentist's phone number?	
What is your new dentist's email address?	
Please send a copy of:	
Please send a copy of:	

RELEASE OF RECORDS AUTHORIZATION

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email to pineviewfamilydental@gmail.com.

Practice Name: PineView Family Dental
Practice Address: 680 Gail Gardner Way, Prescott, AZ 86305, USA
Practice Phone number: (928) 445 9233

Patient's signature:

Date:



PineView Family Dental

680 Gail Gardner Way, Prescott, AZ 86305, USA

(928) 445 9233

www.pineviewfamilydental.com/

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Patient's signature:

Date: