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 and/or mailing address):

_____
_____
_____
_____

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

Patient Signature: _____ Date: _____

Please email or fax this form to:
info@stonebridgeranchdentistry.com
Fax: 972-542-6691

Stonebridge Ranch Dentistry
3595 S. Custer Rd Suite 100
Mckinney, TX 75070
972-542-6662