

SUNDANCE

FAMILY DENTISTRY

Dental Records Release

Date:

Patient:

Birthdate:

Dentist or Practice Name:

Address/Email:

Phone Number/Fax Number:

Personal Email (a copy of the xrays will be sent to you as well):

- My permission is granted to RELEASE complete information concerning the dental findings and treatments from the office listed above; including x-rays, periodontal probing charts, photographs, etc TO Sundance Family Dentistry.

Please email digital records to: office@sundancedentistry.com

-OR-

- My permission is granted to FORWARD any x-rays and other information regarding my dental health FROM Sundance Family Dentistry to the office listed above.

Please sign and email or fax back to our office at (855)208-2359.

****PLEASE ALLOW UP TO 48 HOURS FOR RECORDS TO BE FORWARDED****

Signature