Uptown Dental
Mathias & Olson

642 Harrison Street
Port Townsend, WA 98368
Tel: (360) 385-4700 Fax: (360) 379-9730

Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____

Phone Number: _____

Other Family Members to Transfer:

_____

You have my permission to release my dental records to the following persons:

New Dentist or Practice Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Records released include: (check all that apply)

X-rays _____

Copy of Perio Chart _____

Copy of Chart Notes _____

Other _____

_____ _____

Patient or Responsible Party Signature **Date**