BRENNER
DENTAL GROUP

Records Release

Patient Name: _____ Date of Birth: _____

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

_____

_____

(OLD OFFICE) I authorize the following clinic to release my records, including Any and all requested dental information, including copies or Photostats of my dental record and radiographs, concerning treatment given to me at:

Dentist/Clinic Name: _____

Phone Number: _____

City/State/Zip: _____

Email: _____

Reason for Leaving:

◯ Moving ◯ Insurance is out of network ◯ Hours of Operation ◯ Billing Problem

◯ Other (Please specify): _____

(NEW OFFICE) I am requesting my records be sent to:

Dentist/Clinic Name: _____

Phone Number: _____

City/State/Zip: _____

Email: _____

_____ _____

Signature of Patient, Parent or Guardian (if under 18)

Today's Date