DENTAL DESIGN STUDIO
1795 W Pointe Drive, Oshkosh, WI 54902-4297

DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

I, _____, give my permission for the release of copies of all current x-rays & clinical records in the possession of Dental Design Studio to disclose to:

_____
Name of Health Care Provider / Plan / Other/ Myself

_____
Address

PHONE: _____ FAX # _____

EMAIL: _____

Please release copies of current x-rays & clinical records of the following family members in addition to myself.

Name: **_____** ***DOB:*** **_____**

Name: **_____** ***DOB:*** **_____**

Name: **_____** ***DOB:*** **_____**

I am aware any warranty with my treatment will be void by transferring to another office.

The reason I am transferring is:

_____

_____

_____

SIGNATURE OF PATIENT / LEGAL REP:

_____DATE: _____

If signed by a person other than the patient, complete the following: Individual is: ☐ parent* ☐ legal guardian ☐ legally incompetent ☐ incapacitated deceased ☐ next of kin / executor of deceased