

Tangerine Family Dentistry

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DENTAL RECORDS RELEASE FORM

Date: _____

To Dr. _____

Phone: _____

Email: _____

I, _____, hereby authorize the release of any and all dental records to Tangerine Family Dentistry for ☐ myself ☐ my family.

I release you from all legal responsibility that may arise from this authorization.

Please forward the following information and **recent radiographs taken in the last 2 years.**

Date of:

- Last new/ complete patient exam: _____
- Last recall exam: _____
- Last treatment in your office: _____
- Last bitewing radiographs: _____
- Last panorex radiograph: _____

Number of units of scaling in the last 12 months: _____

Patient Signature

Office Stamp