DENTAL RECORD RELEASE FORM

Patient name to transfer: _____

Date of Birth: _____ Phone Number: _____

Other family members to transfer (and their dates of birth):

_____

_____

Previous Dentist or Practice Name: _____

Address: _____

City/St/Zip: _____

Phone Number: _____ Fax: _____

Please forward any of the following information that you have: X-rays, probing depth chart, charting, and photographs to Crossroads Dental, Dr. Amy Farmer.

I hereby give you permission to release any and all of my dental records to Dr. Amy Farmer.

Signature (or parent of minor): _____ Date: _____

If records are digital, please email them to: dramyfarmer@gmail.com

Or mail them to**:**

Crossroads Dental
Dr. Amy Farmer
1520 South Hover Street, Suite E-F
Longmont, CO 80501

Thank You!