Penniall Family Dental
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RECORDS RELEASE REQUEST FORM

Please fill out this form if you would like your records sent to us from another office.

PATIENT INFORMATION

Patient Name: First Last **Date of Birth:**

Address: Street
City State Zip

Please Select One: ▢ Self ▢ Entire Family

AUTHORIZATION

***TO:**

FAX NUMBER:

**Please indicate the name of the office or dentist that should send your records*

I hereby authorize the release of my records/x-rays or copies of such and request that they be transferred to Penniall Family Dental.

Signature of Patient or Responsible Party _____ Date _____

Relationship to the patient _____ Name if not the patient _____

★ Please email x-rays to **records@pennialldental.com** ★