

Dry Creek Dental
Dental Records Release Form

Patient name _____
Date of Birth _____
Home Phone _____ Cell Phone _____
Work Phone _____

Other family members to transfer:

*Please include name and DOB

Office you're transferring from/to:

*Please include office name and phone number

I, hereby authorize the release of all my dental records and information.

Signature

Date

Dry Creek Dental
Office 307-634-9111 / Fax 307-634-5703
drycreekd@gmail.com

Notes: (for office use only)