

Gregory S. Brya, DDS, PLLC

drbrya.com

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(517)381-8181

Record Release / Access Form: To Another Office

Patient Name: _____ *
Last First MI Preferred Name

Date of Birth: * _____

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Last First MI Preferred Name

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Records to Release/Access: *

FMX or Bitewing (No Charge)

Treatment Information (Fees will apply)

I authorize the release of dental records and X-rays from the office of Gregory S. Brya, DDS, PLLC of the above patient(s) to:

New Dentist Information:

Name: _____

Address: _____

Phone Number: _____

E-Mail Address: _____

Fax Number:

Patient Information:

Name: *

Signature of patient, parent or guardian (responsible party):

Signature _____ Date _____

Relationship to Patient: *

Spouse Child Parent Guardian Other

Date: * _____

Response Date: _____