RECORDS RELEASE REQUEST

Previous Dentist: _____

Address: _____

Phone: _____ Fax: _____

I authorize the release of a hard copy of my dental treatment records and digital copies of all of my x-rays, including CT scans, transferred to:

Dentistry by April Detar, LLC
2182 Sandy Dr. Suite 102
State College, PA 16803
Phone: 814-234-4444
Fax 814-954-5652
Email: info@dentistrybyaprildetar.com

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Please list additional family members you're requesting to be released:

Name: _____ DOB:_____

Name: _____ DOB:_____

Name: _____ DOB:_____

Name: _____ DOB:_____

Name: _____ DOB:_____