PLEASE FILL OUT AND SEND TO YOUR PREVIOUS DENTIST

Authorization for release of dental records

I hereby authorize the office of Dr._____

_____

_____

to release my dental records to:

Park Family Dentistry, DMD
110 Hopewell Road Suite 1B
Downingtown, Pa 19335

Email: parkfamilydentistrydmd@gmail.com

Patient:_____

Address:_____

_____

_____

Date of Birth:_____

Date:_____ Patient Signature:_____