vitek
Family Dentistry, P.C.

Records Release

I, _____, authorize the release of dental records and current radiographs (or copies of such) relevant to dental treatment for myself and my dependants whose names are listed below. Requested dental records include current x-rays, patient note history, specialist reports, or any other documentation that would be beneficial in providing a comprehensive dental history.

Names of Dependants:

_____ _____ _____

_____ _____ _____

I request that they be transferred to:

Vitek Family Dentistry, P.C.

Alexa M. Vitek, D.D.S.

13173 Schavey Road

DeWitt, MI 48820

Phone: 517.277.2000 **Facsimile:** 517.277.2100

Email: vitekfamilydentistry@gmail.com

(Electronic submission is preferred if available due to our electronic dental records.)

Print Patient or Parent/Guardian Name: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Please mail to your previous dentist at least 2 weeks prior to your new patient appointment with our office. Thank you! We appreciate your cooperation!

Name of Previous Dentist: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____