William R. Warren, D.D.S.

Warren Dental Center South
1241 W. Clemmonsville Rd.
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xrays@drwarrendental.com

Release of Dental Records

I hereby authorize _____ to release the records
(name of previous dental office)

of _____ DOB: _____/_____/_____
(patient name)

of _____ DOB: _____/_____/_____
(patient name)

of _____ DOB: _____/_____/_____
(patient name)

please transfer the records, or copies of the records, to the following email address:

xrays@drwarrendental.com

[NOTE: When transferring information we only require current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and treatment dates for prophy's (cleanings), exams, scale & root planning.]

I agree to release William R. Warren, D.D.S. from any liability that may occur as a result of transferring these records.

Signature: _____ Date: _____/_____/_____
(parent/guardian)

Date released: _____/_____/_____ Sent by: _____