Bullis Pond Dental
DR. CF TRAVIS

PREVENTIVE CARE • **SMILE DESIGN** • RESTORATIVE CARE

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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

☐ For transfer of records **TO** Bullis Pond Dental

☐ For transfer of Records **FROM** Bullis Pond Dental

I, _____(print name), hereby request the disclosure of Information from my dental records on file with your office.

Patient Name: _____

Date of Birth: _____

Previous Dental Office/ Doctor: _____

_____

Patient/Guardian Signature *Date*

TO BE COMPLETED BY PREVIOUS DENTIST:

Date of last Prophy/Perio Maintenance/ Scaling Root Planing:

_____

Date of Last FMX/Pano/BTW:

_____