



Bullis Pond Dental

PREVENTIVE CARE • SMILE DESIGN • RESTORATIVE CARE

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Eau Claire, WI 54701
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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:
