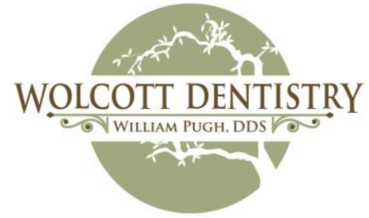
Wolcott Dentistry

6010 Draper Street, Wolcott, NY 14590
315.594.8611



Dental Records Release

Use: *Please use this form to ask your previous dentist to release your records to our office, or if you need us to release your records to another office.*

Instructions**:** *Please print this form and complete with all the requested information. Mail it to or drop it off at the Wolcott Dentistry office. Copies of the requested dental records will be provide to the identified individual or office. Thank you for being our patient and we wish you positive future dental experiences.*

Please provide copies of all my dental records, including diagnostic x-rays. I understand that original records and x-rays are the property of the dentistry practice. I agree to accept copies and pay reasonable fees for such copies.

Patient Name (Print): ____
Patient address: ________________________________
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I request the records for the following additional patients for whom I am the legal guardian:

_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________
_________________________________ _________________________________

Patient/Parent/Guardian
Signature: ____
Date: ________________________________

Witness Name (Print): ____
Witness Signature: ____
Date: ________________________________

Send Records To: ____
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