Dental Records Release Form

Patient Name to transfer: ____

Date of Birth: ____________________ Phone number: ____________________

Other family members to transfer: ____

Previous Dentist or Practice Name: ____

Address: ____

City/St/Zip : ____

Phone number: _________________________

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Chapman Orthodontics.

I hereby give you permission to release any and all of my dental records to Joshua A. Chapman DDS, MSD.

____________________________________ ___________________

Patient Signature (parent if a minor) Date

If records are digital, please email to:

chapmanorthodontics@gmail.com

Or mail to:

Chapman Orthodontics
3925 East Hagan St., Ste. 201
Bloomington, IN 47401