



RELEASE OF RECORDS AUTHORIZATION

| DOB:

Please select which scenario applies to you	
What is your previous dentist's name/practice name?	
What is your previous dentist's address?	
What is your previous dentist's phone number?	
What is your previous dentist's email address?	
What is your new dentist's name/practice name?	
What is your new dentist's address?	
What is your new dentist's phone number?	
What is your new dentist's email address?	
Please send a copy of:	
Please send a copy of:	

RELEASE OF RECORDS AUTHORIZATION

By signing below, I consent for my dental treatment records and/or x-rays to be transferred by email to info.massiedental@gmail.com.

Practice Name: Massie Dental
 Practice Address: 200 N. Giant City Rd., Carbondale, IL 62902
 Practice Phone number: (618) 529-2711

Patient's signature:

Date:



Massie Dental

200 N. Giant City Rd., Carbondale, IL 62902

(618) 529-2711

www.massiedental.com

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Patient's signature:

Date: