RON MAMRICK DDS, PC
FAMILY & COSMETIC DENTISTRY

REQUEST FOR RELEASE OF DENTAL RECORDS AND/OR X-RAYS

Previous Dentist Information

Dentist Name: _____

Phone Number: _____

Address: _____

_____

_____

I hereby authorize _____ to release a photocopy of dental treatment records, original or duplicates of most recent full series and bitewing x-rays, as well as any records relating specifically to dental implants for the following patient.

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

_____

_____

Please email the x-rays and chart notes to: info@MamrickDentistry.com or mail them to:

Ronald C Mamrick, DDS PC
1807 Huguenot Road, Suite 124
Midlothian, VA 23113
Phone (804) 423-1600
Fax (804) 423-1602

_____ _____ _____

Patient or Guardian Signature | Relationship to Patient | Date