

Dental Record Release Form

___I authorize the release of my dental records including **chart notes, xrays and perio charts**. I request that they be sent to:

Bellaire Family & Cosmetic Dentistry
Elk Rapids Family & Cosmetic Dentistry
c/o 4631 S M88 Hwy
Bellaire, MI 49615
Telephone: (231)533-8712
Fax: (231)533-4142
Email: bfgcd@bellairedentistry.net

___I authorize Bellaire Family & Cosmetic Dentistry & Elk Rapids Family & Cosmetic Dentistry to release my records to:

Patient Name: _____

DOB: _____

Patient, Parent or guardian signature: _____

Date: _____

Please provide previous dentists and dental specialists: _____
