Lane & Associates
Family Dentistry

Dental Records Release Form

Patient Name: _____ Date: _____

Patient Date of Birth: _____

My permission is granted to Lane and Associates Family Dentistry to forward any needed records and x-rays to my future dental facility. I release Lane and Associates from any laws related to disclosure of confidential or privileged information.

Release x-rays to: _____
_____
_____
_____

_____ _____
Signature **Date**

_____
Printed Name

Reason for Request:

____ Moving/Relocating

____ Other (please specify reason): _____
_____
_____
_____

Please check relationship to patient: _____ Self _____ Parent/Guardian
_____ Legal Representative