Records Release Request

Date:

Previous Dentist:

Address:

Phone #:

Fax #:

I authorize the release of my dental records to:

Palm Ridge Dental
prd1@palmridgedental.net
Ph: (352) 391-9930
Fax: (352) 391-9052

(If your office has digital radiograph technology we would prefer that current radiographs are emailed to us.)

Printed Name of Patient or Guardian **Date of Birth**

Signature