Dental Records Release Form

Name of Patient: _____

Date of Birth: _____ Phone number: _____

Previous Dentist: _____

Address: _____

City/St/Zip: _____

Phone number: _____

Please forward the following information (please circle all that apply):

- Dental x-rays
- Probing depth chart
- Charting
- Current treatment plan
- Photography

I hereby give you permission to release any and all of my dental records to Cascade Dental, PC.

_____ _____

Patient Signature (parent it a minor) Date

Please email records to: cascadedentalid@gmail.com

or

Mail records to Cascade Dental
PO Box 760
Cascade, ID 83611