Dental Records Release Form

Patient Name to transfer: _____

Date of Birth: _____ Phone number: _____

Other family members to transfer: _____

Previous Dentist or Practice Name: _____

Address: _____

City/State/Zip: _____

Phone Number: _____

Please forward any of the following information that you have: x-rays, probing depth chart, charting, and photographs to Dr. Mark Schwartz DMD.

I hereby give you permission to release any and all of my dental records to Dr. Schwartz.

_____ _____

Patient Signature (parent if a minor) Date

If records are digital, please email to:
mrkschwrtz9@gmail.com

Or mail to:
Dr. Mark Schwartz DMD.
501 Main Street Ste. 106
Monroe, CT 06468