Dental Records Release Form

Patient Name to Transfer: ____

Date of Birth: _________________ Phone number: ___________________

Other family members to transfer: ____

Previous Dentist: Dr. Heather L. Skari Family Dentistry
4110 40th Street South Ste 103 Fargo, ND 58104
Fargo, ND 58104
701.293.7996

I hereby give you permission to release any and all of my dental records to:

____

____ ____________________________

Patient Signature (parent if minor) Date

If records are digital, please email to: ____

(We do need the email address to send your x-rays.)

New Dental Home:

Dentist or Practice Name: ____
Phone Number: ____