Dr. Heather L. Skari
FAMILY DENTISTRY

# Dental Records Release Form

Patient Name to Transfer: _____

Date of Birth: _____ Phone number: _____

Other family members to transfer: _____

Previous Dentist: _____

Address: _____

City/St/Zip: _____

Phone number: _____

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

_____ _____

Patient Signature (parent if minor) Date

If records are digital, please email to:

office@skarifamilydentistry.com

Or mail to:

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