MODERN DENTISTRY of NEW ENGLAND

DENTAL RECORDS RELEASE FORM

I, ____ _____/_____/_______

Print Name Date

Herby request, and authorize the release of dental records.

From the office of: Sherif Gabr DDS / Modern Dentistry of New England.

And request they be transferred to: ☐Patient/parent/legal guardian ☐Provider of my choice

Name of Dental Office:____

EMAIL To:____

PHONE: ____________________________ FAX # ____________________________________

Name of Patient:___________________________________ Date of Birth:____/____/_________

Name of Patient:___________________________________ Date of Birth:____/____/_________

Name of Patient:___________________________________ Date of Birth:____/____/_________

When transferring information to another dental office we **only send** current x-rays (bitewing x-rays, full mouth x-rays & Panorex) within the last 5 years.

By signing, I understand that the information released per this authorization, if re-disclosed by the recipient, is no longer protected by Sherif Gabr DDS/Modern Dentistry of New England.

SIGNATURE OF PATIENT / LEGAL REP:

____DATE: _________________

If signed by a person other than the patient, complete the following: Individual is:

☐ parent* legal guardian ☐ legally incompetent

225 N. Main St. Bristol, CT. 06010 Office # (860)582-4485 Fax# (833)650-8864