DAVIS
DENTISTRY

Records Release Form

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Date: _____

Date of birth _____

Your Name: _____

Address: _____

_____

_____

Leaving the practice Or Alternating Offices:

☐ I, _____ authorize the release of my records to:

Doctors name, address, phone #, and e-mail: _____

_____

_____

Reason for leaving: [ ] Second Opinion [ ] Office closer to home [ ] Moving
[ ] Other _____

*Duplicate x-rays will be sent at no charge. If you would like a copy of your entire records, there is a $25.00 duplication fee and may take up to 14 days.

Retrieving Records from another office:

☐ I, _____ would like my dental x-rays and periodontal charting released to Dr. Mark S. Davis office. Please send them by mail at 31309 N. Scottsdale Rd. Suite 125, Scottsdale, AZ 85266 or by e-mail at mdavisdentistry@gmail.com.
If you have DEXIS software? Please send them via Dexis format.

Doctors name, address, phone #, and e-mail: _____

_____

Signed _____**Date** _____

***Please email release to mdavisdentistry@gmail.com or Fax to 480-595-0274**