PATUXENT DENTAL

44210 Airport View Dr
Hollywood, MD 20636
Office: 301.373.3230
Fax: 301.373.3057
patuxentdental2@gmail.com

Records Release Form

Request Date: _____

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

I hereby give (office/ physician) _____

_____

permission to release all dental records to include all radiographs, charting, photographs, and any other pertinent information to Patuxent Dental, LLC. Please send them by email to patuxentdental2@gmail.com. Thank you!

Patient/Guardian Signature Relationship to Patient