**DENTAL RECORDS TRANSFER**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient Name: |  |  |
| DOB: |  |  |
| Phone Number: |  |  |

|  |  |  |
| --- | --- | --- |
|  |  | **Records Sent from:** |
|  |  |  |
| Pruitt & Earp Dentistry |  |  |
|  |  |  |
|  |  |  |

***Please email (if possible) XRays to:***

XRAYS@Pruittearpdentistry.com

I hereby authorize the release of my medical records to the above stated office.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Patient or Guardian Signature |  | Date |

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