We have received a request for your current x-rays from another dental office. Please complete this form, sign, date and return it to our office. Upon receipt of this completed release form we will forward current x-rays. Please make sure all appropriate parties have signed and dated the form. Thank you.

I authorize Commerce Drive Dental Group to release my x-rays /records to:

_____

(Name of dental office)

_____

(Address – if known)

_____

(E-mail address – to expedite the transfer of records)

Name: _____DOB: _____

Signature: _____

EMAIL ADDRESS (**Required**) _____

SPOUSE:_____DOB:_____

*Signature:_____

CHILDREN:_____DOB_____

*Signature (if over18)_____

To better service our patients, may we ask your reason for leaving?

___Financial ___Insurance ___Location ___Moved ___Unhappy ___*Other

Please Specify: _____

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