

# RELEASE OF DENTAL RECORDS

Previous Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

I hereby request the release of all dental records including radiographs and daily treatment notes to be forwarded to:



Amit V. Desai, DMD  
Elana C. Celliers, DMD  
435 Highland Avenue Suite 210  
Cheshire, CT. 06410  
(203)272-7271  
Fax (203)272-8882  
[office@addentistry.com](mailto:office@addentistry.com)

☐ JPEG ☐ Dexis ☐ Hard copy/reg. mail

\*\*(Please e-mail individual films with dates)

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Patient/Guardian

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## For Office Use Only:

Date release form was faxed: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

Notes: (if you spoke to someone at previous office-what hx do they have?)

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