

**Records Release/Request:**

**I hereby authorize the release of my dental records and my most recent dental x-rays. Please include a panoramic film it one was taken within the last 3 years. I request they be transferred to (Please circle one):**

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| --- | --- | --- |
| **Saratoga Springs****Family Dentistry****286 Church Street****Saratoga Springs, NY 12866****518.584.8150****Fax 518.584.8751****saratogafd.office@okrinse.com** | **South Glens Falls****Family Dentistry****63 Hudson Street****Glens Falls, NY 12803****518.792.2187****Fax 518.792.2188****sgf@okrinse.com** | **Gloversville****Family Dentistry****22 First Ave****Gloversville, NY 12078****518.725.1031****Fax 518.773.4310****gloversville@okrinse.com** |
| **Clifton Park****Family Dentistry****983 Route 146****Clifton Park, NY 12065****518.371.3333****Fax 518.952.4331****cliftonpark@okrinse.com** | **Greenwich****Family Dentistry****2651 State Route 40****Greenwich, NY 12834****518.692.9333****Fax. 518.692.9696****greenwich@okrinse.com** | **Queensbury****Family Dentistry****453 Dixon Rd Suite 5****Queensbury, NY 12804****518.792.1108****Fax 518.798.4670****queensbury@okrinse.com** |

\*\* Please mail or fax this form to your previous dentist prior to your appointment. It is very helpful and will save time if your records are available for us at your exam!

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Dentist Information:**

**Dental Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_