RESTORATIVE, COSMETIC & FAMILY DENTISTRY

GREGSON & ASSOCIATES
DENTISTRY

JEFFREY
GREGSON, DDS

AUTHORIZATION TO RELEASE DENTAL RECORDS

INFORMATION

Name (Full) _____ Birthdate _____
FIRST NAME / MIDDLE INITIAL / LAST NAME — MM / DD / YYYY

I AUTHORIZE MY RECORDS TO BE TRANSFERRED FROM THE FOLLOWING OFFICE:

Dentist or Office Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Email _____

I AUTHORIZE GREGSON FAMILY DENTISTRY TO SEND MY RECORDS TO:

Dentist or Office Name _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Email _____

RECORDS TO BE TRANSFERRED:

- ☐ X- R a y s
- ☐ Periodontal Charting
- ☐ Treatment Plan

REASON FOR TRANSFER:

- ☐ Relocating or Moving
- ☐ Change in Insurance
- ☐ Other: _____

Email records to:
info@gregsondentistry.com

Patient's Signature _____ Date _____