

## Release of Records

Please transfer copies of dental treatment records, including diagnostic x-rays and any other materials, notes of copies of medications prescribed. I understand that original records and x-rays are the property of PDA Dental Group. I agree to accept copies and to pay reasonable fees for such copies as deemed necessary by the office.

Date of Request: \_\_\_\_\_ Date Required: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Release to Mr/Ms: \_\_\_\_\_

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ (all emails are sent securely)

**OR**

Release to Dr. \_\_\_\_\_

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

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ (all emails are sent securely)

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patients who are 18 years of age or older must sign the request)

Reason for Transfer: \_\_\_\_\_

**Pediatric Dentistry**

Dr. Gary Warrington, DMD  
Dr. Sonia Wu, DMD  
Dr. Nicole Harrington, DMD  
Dr. Matthew Freitas, DMD  
Dr. Sean Ghassem-Zadeh, DMD  
Dr. Patrick Cooper, DMD  
Dr. Karina Vergara, DMD

**Orthodontics**

Dr. Shannon Duffy, DMD  
Dr. Carolyn Ferrick, DMD

**Adult Dentistry**

Dr. Kimberly Weiss, DDS  
Dr. Melissa Torres, DDS