



## RELEASE OF INFORMATION REQUEST

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

I \_\_\_\_\_ Hereby request and authorize

\_\_\_\_\_ Phone number: \_\_\_\_\_

(Name of prior dentist/office)

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

to release all records of FMX, BWX, perio chart to Freeport Family Dentistry.

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

Other Family Members: \_\_\_\_\_ Date(s) of Birth: \_\_\_\_\_

X \_\_\_\_\_

Signature of Patient or Guardian

Each adult must sign permission to forward records for self (as per Federal Privacy Act)

\*Please send records to: **info@freeportfamilydentistry.com** BEFORE: \_\_\_\_\_

Date of appointment

*Thank you!*  
123 Main Street, Freeport,  
NY 11520  
+1 (516) 123-5467