AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Phone:** _____

PREVIOUS DENTAL PRACTICE INFORMATION

I hereby authorize the following dental provider/practice to release my complete dental records:

Practice / Doctor Name: _____

Phone: (_____) _____ **Email:** _____

Address: _____

City: _____ **State**: _____ **ZIP:** _____

RECORDS REQUESTED

To ensure continuity of comprehensive care, please forward the following information to Slate Dental:

- Current Full Mouth Series (FMX) or Panoramic X-rays
- Most recent Bitewing and Periapical X-rays
- Current Periodontal Probing Depth Chart
- Comprehensive Treatment Charting and Clinical Notes
- Intraoral and Extraoral Photographs

AUTHORIZATION

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatments provided, diagnostic imaging, and all other records

which pertain to my dental care. I hereby give my explicit permission to release all of my dental records to Dr. John Slate.

Signature of Patient: _____

(or Parent/Guardian if applicable)

Printed Name: _____ **Date:** _____

INSTRUCTIONS FOR SENDING OFFICE

Please forward all requested records to Slate Dental at your earliest convenience.

DIGITAL TRANSFER (PREFERRED)

Please email all digital x-rays, photos, and charts to: **contact@slatedentaldc.com**

PHYSICAL MAILING ADDRESS

Slate Dental

3301 New Mexico Ave NW, Suite #332

Washington, DC 20016

Phone: (202) 686-5222