West Somerville Dental ASSOCIATES

**P: 617-625-0543 F: 617-666-5034**

# Patient Record Release Form

**Name:**

**Date :**

**Purpose of release:**

___Second Opinion

___Leaving Practice

If leaving, please elaborate reason for transferring:

**I authorize West Somerville Dental Associates to forward a copy of my records to the following dental practice:**

**Practice Address:**

**Please transfer:**

___Copy of dental x-rays

___ Copy of all treatment rendered in this office

___Limited to treatment dates & for conditions described below:

**Patient, Parent or Guardian Signature:_____ Date_____**