RECORDS RELEASE REQUEST

Date_____

To_____
(Former Dentist's Name)

Address_____

City_____ State_____ Zip_____

Telephone #_____Fax#_____

Email Address_____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

Ferguson Dental Associates
David I. Ferguson, D.D.S.
177 Gordonhurst Avenue
Upper Montclair, NJ 07043
(973) 744-3181
Fax # (973) 337-8648
Email address: frontdesk@fergusondental.com

_____ _____
Print Name of Patient

_____
Signature (patient, parent or guardian)

We utilize Dexis Digital Radiographs so if at all applicable please email radiographs in Dexis format.