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Release of Records Form

Date_____

I, _____, give permission to have my records and x-rays from _____ forwarded to Mount Pleasant Dental Care, along with the family members listed below. Thank you for your assistance.

Signed _____

Date of Birth _____

Name _____Date of Birth _____

Name _____Date of Birth _____

Name _____Date of Birth _____

If records or x-rays are digital, please email to: info@mountpleasantdental.com

Or Mail/Fax to:

Mount Pleasant Dental Care
PO Box B
West Rockport, ME 04865
Ph: 207-230-0110
Fx: 207-230-1116