Request for Release of Records

Date: _____

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To: Pickerington Family Dental
164 Clint Dr.
Pickerington, OH 43147
Phone: 614-367-1740

Email for Xrays: pickeringtonfd@mydentalmail.com
Fax: 614-367-1760

Patient Name and DOB: _____

Please Send:

☐ Most Recent Xrays
☐ Periodontal Charting
☐ Outstanding Treatment
☐ Chart Notes

Patient's Signature:_____ Date:_____