DENTAL RECORDS RELEASE FORM

DR. AMANDA RENTSCHLER
DR. EMILY HOBART
1210 ROOSEVELT AVENUE
MOUNT VERNON, WA 98273
(360) 424-5650

Patient name to transfer: _____
Date of birth: _____

Phone number: _____

Other family members to transfer: _____

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Previous dentist or practice name: _____

Address: _____

City/State/Zip: _____

Phone number: _____

Fax: _____

Please forward any x-rays, photos, and periodontal charting that you may have.

I hereby give you permission to release any and all of my dental records to Roosevelt Dental Center of Skagit County.

Patient/Guardian Signature: _____ Date: _____

Email to: frontdesk@rooseveltdentalcenter.com Fax to: (360) 424-9672