Record Release Request

Date: __________________

Previous Dental Office: ___________________________

Address: ____

City: _________________________ State: _________ Zip: ____________

I request and authorize the release of dental records and x-rays to dental treatment, or copies of such, and request they be transferred to: office@firstimpressiondentistry.com, if unable to transfer records via email please mail to the address below.

Patient's name:___________________________________

Date of Birth: _____________________________________

Signature: ____

If patient is a minor, relationship to patient: ____________________________

315 West Kemper Road Cincinnati, Ohio 45246 513.772.8840