



PACIFIC CREST
DENTAL GROUP

Dental Records Release Form

Patient Transferring: _____

Date of Birth: ____ / ____ / ____ Telephone Number: (____) _____

Current Address: _____

Transferring records out of Pacific Crest Dental Group to a new provider:

New provider's name:

Address: _____

Office e-mail: _____

Transferring records to Pacific Crest Dental Group:

My previous dental provider's information:

Dentist or Office Name: _____

Address: _____

Email (print clearly*) or phone contact: _____

Please send digital records to: docbonar@pacificcrestdental.com

I hereby grant permission to **Pacific Crest Dental Group** to release or obtain information related to my dental/medical history, clinical notes and x- rays/photos to the above noted recipient.

Patient Signature (parent if minor)

Date