Queensgate Dental

Only brush the ones you want to keep!

Authorization to Release Dental Information to Queensgate Dental

Previous Dentist/Practice: _____

Address: _____

Phone#: _____ *Fax #:* _____

Release

Patient Name: _____ *DOB:* _____

Address: _____

I hereby give permission to release any and all of my patient dental records/x-rays to Queensgate Dental Practice.

Please include family members: _____

_____

_____ _____

Patient (Guardian if minor) Signature *Date*

Please send records to:

Queensgate Dental/ William H Cloyd DMD
2087 Springwood Road, York, PA 17403

Electronic Email: queensgatedental1@gmail.com

Phone: (717) 843 8011 Fax: (717) 843 4414 (no x-rays)