

Queensgate Dental

Only brush the ones you want to keep!

Authorization to Release Dental Information to Queensgate Dental

Address: Fax #: Phone#: Fax #: Pone#: Fax #: DOB: Patient Name: DOB: Patient Name: DOB: Poly give permission to release any and all of my patient dental records/x-rays to Queensgate Dental Practice. Please include family members: Date Patient (Guardian if minor) Signature Date Please send records to: Queensgate Dental/ William H Cloyd DMD 2087 Springwood Road, York, PA 17403	Previous Dentist/Practice: _			
Release Patient Name:	Address:			
Patient Name:	Phone#:	Fax #:		
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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	Patient Name:		DOB:	
Queensgate Dental Practice. Please include family members: Patient (Guardian if minor) Signature Date Please send records to: Queensgate Dental/ William H Cloyd DMD	Address:			
Please send records to: Queensgate Dental/William H Cloyd DMD				
Queensgate Dental/ William H Cloyd DMD	Patient (Guardian if minor)	Signature	<i>y</i> :	Date
	Please send records to:			
Electronic Email: queensgatedental1@gmail.com	2087 Springwood Road, Yor	k, PA 17403		

(717) 843-8011, Queensgate Towne Center, 2087 Springwood Road, York, PA 17403, queensgatedental.com

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