LANGHORST
FAMILY DENTISTRY PLLC

Records Release

I, _____, authorize the release of dental records and current radiographs (or copies of such) relevant to dental treatment for myself and my dependents, whose names are listed below. Requested dental records included current x-rays, patient note history, specialist reports, or any other documentation that would be beneficial in proving a comprehensive dental history.

Names of Dependents:

_____ _____ _____

_____ _____ _____

_____ _____ _____

I request that they be transferred to:

Langhorst Family Dentistry, PLLC
Sarah Langhorst, DDS
3235 North Wellness Drive, Suite A-240
Holland, MI 49424
Phone: 616-377-7708
Email: info@langhorstfamilydentistry.com
(Electronic submission is preferred if available due to our electronic dental records.)

Print Patient or Parent/Guardian Name: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Please mail to your previous dentist at least 2 weeks prior to your new patient appointment with our office. Thank you! We appreciate your cooperation!

Name of Previous Dentist: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____