KILMAN DENTAL
Gentle Caring Dentistry

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REQUEST TO RELEASE DENTAL RECORDS:

I hereby authorize and request ______________________ to disclose and give copies to Dr. Joseph Kilman DMD, any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following: **dental records including Perio charting, treatment plans, dental history, findings and procedures, x-rays/intra-oral photographs** or any other pertinent information pertaining to my dental work.

Dental x-rays: FMX and/or Pano 5 years old and newer, Bitewing x-rays 2 years old and newer. If x-rays are digital please copy onto a CD or send by e-mail.

In consideration of such disclosure on the part of the above named person or institutions, I hereby release them from any and all liability arising from such disclosure.

Patient Name(s): ________________________________ **Birth date:** ______________________

Patient/Parent Signature: ____

Date: ____

Previous Dentist Address: ____

Dentist Phone #: ___________________________________

Dentist Fax #: _____________________________________