YOUR COMMUNITY
DENTAL

Release of Records

Patient Information:

Patient Name to Transfer: _____

Date of Birth:_____

Phone Number:_____

Dental Office Information:

Dental Practice and Name of Treating Dentist:_____

Address:_____

City/St/Zip:_____

Phone Number:_____

Please forward the following:

Radiographs, Periodontal Charting, Recommended Treatment

I hereby authorize the release of any and all dental records for the patients listed above to Schryer and Associates, DDS, PLLC for the use of continued care.

_____ _____

Signature Date

If records are digital, please email to:

frontdesk@yourcommunitydental.com

Or mail to:

Schryer and Associates, DDS
c/o Dental Records
1611 Greenfield Street
Wilmington, NC 28401