

Release of Records

Please transfer copies of dental treatment records, including diagnostic x-rays and any other materials, notes of copies of medications prescribed. I understand that original records and x-rays are the property of PDA Dental Group. I agree to accept copies and to pay reasonable fees for such copies as deemed necessary by the office.

Date of Request: _____ Date Required: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Name of Patient: _____ DOB: _____

Release to Mr/Ms: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____ (all emails are sent securely)

OR

Release to Dr. _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____ (all emails are sent securely)

Patient/Parent/Guardian Signature: _____ Date: _____

(Patients who are 18 years of age or older must sign the request)

Reason for Transfer: _____

Pediatric Dentistry

Dr. Sonia Wu, DMD
Dr. Nicole Harrington, DMD
Dr. Matthew Freitas, DMD
Dr. Sean Ghassem-Zadeh, DMD
Dr. Patrick Cooper, DMD
Dr. Karina Vergara, DMD
Dr. Kristen Huber, DMD

Orthodontics

Dr. Shannon Duffy, DMD
Dr. Kieran Mullarney, DMD

Adult Dentistry

Dr. Kimberly Weiss, DDS
Dr. Melissa Torres, DDS