

Dental Collaborative
4452 Washington Street
Roslindale, MA 02131

Dental Record Release Form

Patient Transferring: _____

Date of Birth: ____/____/____ **Telephone Number:** _____

Current Address: _____

- ☐ **Transferring Records out of Dr. Treon's office to a new provider:**

New provider's name: _____

Address: _____

Office email: _____

I hereby grant permission to Harry P. Treon, D.M.D./Dental Collaborative to release information related to my dental records, clinical notes and x-rays/photos to the above noted recipient.

Patient Signature (*parent if minor*)

Date