FALLSTON FAMILY DENTISTRY
REQUEST TO RECEIVE DENTAL RECORDS

I, ______________________________, DO HEREBY CONSENT AND AUTHORIZE

______________________________ TO DISCLOSE TO KELLY BURK, D.D.S. INFORMATION

IN MY RECORD, INCLUDING CURRENT AND PREVIOUS DENTAL RECORDS FROM OTHER

PRACTITIONERS, HOSPITALS AND/OR CLINICS WHICH ARE PART OF MY RECORD.

THIS INFORMATION IS STRICTLY FOR THE PURPOSE OF IDENTIFICATION.

I ALSO CONSENT TO THE RELEASE OF DENTAL RECORDS BY FALLSTON FAMILY DENTISTRY IN THE EVENT ANY ADDITIONAL INFORMATION IS NEEDED BY MY INSURANCE COMPANY OR OTHER PROVIDERS.

PATIENT: ________________________________ DATE: ____________

PRINT: ________________________________

GUARDIAN SIGNATURE AND RELATIONSHIP TO PATIENT:
____

PLEASE SEND THIS TO: **FALLSTON FAMILY DENTISTRY KELLY BURK, D.D.S.**
1716 HARFORD ROAD, SUITE 100
FALLSTON, MD 21047
Email-drburk@fallstonfamilydentistry.com

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE: 410.877.3818

COPIES OF THE FOLLOWING RECORDS ARE SPECIFICALLY REQUESTED:

- PROGRESS NOTES
- LETTERS OR REPORTS TO/FROM SPECIALIST
- PERIODONTAL CHARTING
- RADIOGRAPHS
- MEDICAL HISTORY FORMS