Gilrain and Brooks, D.D.S., P.C.

Records Release Request

Date:_____

To:_____
Name of Previous Dentist/Dental Office

Patient Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone Number:_____

I authorize the release of dental records (including radiographs), and request that they are transferred to:

Gilrain and Brooks, D.D.S., P.C.
1461 Greenbrier Place
Charlottesville, VA 22901
434-977-7080
info@gilrainbrooksdds.com

Name and Ages of other family members to be transferred:

_____

Signature:_____ **Date:**_____