If you have been to another dentist within the past five years, you can request that a copy of your records (including xrays) be sent to us. This can assist us in diagnosing and may prevent the need for new xrays – saving you both in cost and unnecessary exposure.

Please fill in the name of your most recent dentist/dental office below, and we will forward the request to them. If you would prefer that we not contact your previous provider, or if you do not have recent records, please initial on the next line and sign & date at the bottom.

_____ I do not want my previous dentist/dental office to be contacted for records.
initials

_____ I do not have xrays/records within the past five years.
initials

Release of Records Authorization

I hereby request and give authorization to Dr. _____

_____
Address

_____
City, State Zip

_____
Phone

_____
Fax

to provide copies of all my records (including current xrays) to:

Rockside Family Dental Care
6132 West Creek Road
Independence, OH 44131
(216)524-8481
info@rocksidedental.com

_____ _____ _____
Signature Printed Name Date
(Parent, Legal Guardian or Custodian of patient if patient is a minor)

Records may be mailed or emailed to the contact information listed above.