NEVILLS FAMILY DENTISTRY PC
David E. Nevills, DMD
Megan L. Nevills, DMD

REQUEST FOR RELEASE OF RECORDS

To: _____ (prior dentist/dental office)

I, _____ (patient or parent / guardian / custodian) herby authorize the release of any and all information with respect to the dental treatment of _____ (patient) to Dr. David Nevills, DMD and/or Dr. Megan Nevills, DMD at Nevills Family Dentistry.

I agree to pay the cost of duplicating any records. A photocopy or facsimile of this Release will be effective and valid as the original.

Date: _____
Patient Name (printed): _____
Patient Signature: _____
Parent/Guardian/Custodian Signature: _____
Patient Date of Birth: _____
Patient Address: _____

IF POSSIBLE, PLEASE EMAIL X-RAYS TO:
Office@NevillsFamilyDentistry.com