# DENTAL RECORDS RELEASE FORM

BOWMAN
DENTAL

PO BOX 1199 Walpole, NH 03608 Phone: 603-756-4719 Fax: 603-756-4351
www.bowmandental.com

**Name of Patient(s) Record to be released:** ______________________________________________

**I hereby request that my dental x-rays be transferred from Bowman Dental to:**

Self
*Dental Office:* _____________________________________________________

*Address:* __________________________________________________________

*Phone:* ____________________________________

*to email:* _______________________________
*(Office email) * must be filled out for x-rays to be transferred*

**SIGNATURE OF PATIENT / LEGAL REP:**

_______________________________________________________________DATE: _______________

If signed by a person other than the patient, complete the following: Individual is:

parent* legal guardian
legally incompetent
incapacitated

*Please send completed form back by email to eva@bowmandental.com or mail to address listed above.*