

ANDOVER PEDIATRIC DENTISTRY

MARITZA MORELL, DMD, MS, MPH

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DATE: _____

RE: PATIENT _____ D.O.B. _____

REASON FOR TRANSFER _____

Below please find a dental record release form that must be signed and returned to our office before we can release any records you have requested. There is a \$15.00 per child transfer fee for duplicating records and radiographs that must be paid before we release any records. Please make this check out to Maritza Morell DMD.

Please find an updated statement of account that includes this transfer fee. Kindly pay and update your family account promptly if there is any remaining balance.

Do not hesitate to call our office with any questions you may have.

Thank you.

AUTHORIZATION TO RELEASE DENTAL RECORDS

I am hereby authorizing the office of Dr. Maritza Morell, DMD, MS, MPH to release any dental records and/or radiographs to:

DR. _____

ADDRESS: _____

DR. EMAIL ADDRESS: _____

RE: PATIENT _____ D.O.B. _____

DATE: _____

SIGNATURE: _____

Please circle:

Relation to patient: Mother Father Legal Guardian

Please cancel any appointments currently scheduled with Dr. Morell: Yes No