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:_____

_____

RE:PATIENT_____**D.O.B.**_____

DATE:_____

SIGNATURE:

_____

Please circle relation to patient: Mother Father Legal Guardian