



Permission to Obtain Dental/Medical Records

Dental office of: _____

To whom it may concern,

Patient Name: _____

Patient Date of Birth: _____

Our patient requests that their dental chart and records be sent to Dr. Michael Dyer, DMD in Georgetown, Texas.

(Please include the following:)

Most recent dental cleaning date

Circle One: Prophy or Periodontal maintenance

Periodontal charting

Clinical notes & Ledger

Films:

Bitewings _____
(date)

Pano _____
(date)

FMX _____
(date)

PA _____
(date)

Thank you for your attention to this matter.

Sincerely,

Michael Dyer, DMD

Signed: _____ Date: _____

(Patient, parent, or legal representative)

Relationship to patient: _____

Office Use Only

Today's Date: _____

Fax/Email: _____

Sent By: _____