Authorization to Release Records

Patient Information:	
Full name:	Date of birth:
Address:	
Phone Number:	Email address:
Current Dental Practice Information:	
Name of current dental practice:	
Address:	
Phone Number:	Email address:
New Dental Practice Information:	
Name of new dental practice to be transferred to:	Cameron R. Woodward DMD
Address: 560 Riverside Dr, Suite B-205,	Salisbury, MD 21801
Email address: info@drwoodward.org	
Phone Number: (410) 742 - 0166	Fax Number: (410) 742 - 0161

Patient Consent and Authorization:
I, the undersigned, authorize the transfer of my/patient's dental records from the current dental practice listed above to the new dental practice specified above. This authorization includes, but is not limited to, the release of dental history, treatment records, x-rays, and laboratory results. I understand that this transfer is essential for ensuring the continuity of dental care and treatment.
Patient/legal guardian's name:
Patient/legal guardian's signature:
Date:

Cameron R. Woodward DMD
560 Riverside Dr, Suite B-205, Salisbury, MD 21801
Ph: 410-742-0166, Fax: 410-742-0161; info@drwoodward.org