Dental Records Release Form

Patient Name: _____ Date of Birth: _____

Current Address: _____ Phone: _____

☐ Transferring records to Dr. McPherson's office
My previous dental provider's information:

Dentist or Office Name: _____

Address: _____

Email or Phone Contact: _____

Please send digital records to: tonya@mcphersondds.com

☐ Transferring records from Dr. McPherson's office to a new provider:

New Provider's Name: _____

Address: _____

Email or Phone Contact: _____

I hereby grant permission to D. Shane McPherson, DDS, A Dental Corporation, to release or obtain information related to my dental history, clinical notes, and x-rays/photos to the above named recipient.

_____ _____
Patient Signature (Parent if minor) Date

2129 E. Bert Kouns Ind. Loop Shreveport, LA 71105 Ph: 318-797-1873 Fax: 318-797-8892