Chatham Prosthodontics

Committed to Excellence in the Art of Cosmetic, Implant, and Reconstructive Dentistry

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TRANSFER OF DENTAL RECORDS REQUEST FORM

I, ______________________________ Date of Birth ____________

authorize the release of copies of ALL DENTAL RADIOGRAPHS AND RECORDS to:

Dr. Mauricio Lavie
585 Main Street
Chatham, NJ 07928

These records may be mailed, or emailed. If digital radiographs are available, email is preferred. Please email to: frontdesk@drlavie.com

Dentist ____

Address ____

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SIGNATURE OF PATIENT OR GUARDIAN **DATE**