**Alan I. Newman, DDS**
**Lisa K. Newman, DDS, MS**
*Pediatric Dentistry*
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*General Dentistry*
2024 W. Henrietta Rd.  #1A
Rochester, NY 14623
585.271.4700
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Date of Request: ______________________________

I hereby request and grant permission to ________________________________________________________
*(previous dentist name)*

of ________________________________________________________________________________________
*(address of above named dentist)*

to send my complete dental records, including but not limited to, any available radiographs.

I release the above named provider from any laws related to disclosure of confidential or privileged dental, medical, or personal information relating to this requested records transfer.

Patient Name: _________________________________________________________ DOB: _____________

Dependent Name: ________________________________________________ DOB: _____________

Dependent Name: ________________________________________________ DOB: _____________

Dependent Name: ________________________________________________ DOB: _____________

Dependent Name: ________________________________________________ DOB: _____________

Patient Address: _______________________________________________________ Phone: ___________

Signature: _________________________________________________________________________________
*(patient or person authorized to consent for patient)*

**Attention dental associate:** If possible, please forward records in jpeg form by e-mail to rochfamilydental@gmail.com.  In the subject line, please indicate the name of the patient(s) so we know it is safe to open.  Also, we kindly request the films be sent as individual images as opposed to in “mount” form labeled with patient’s name, date of birth, and date of service.  Thank you very much for your consideration to this request.