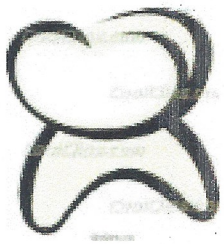

Dental Records Release Form

Patient Name To Transfer:_____

Date of Birth: _____Phone Number:_____

Other Family Members To Transfer:_____

Previous Dentist or Practice Name:_____

Address:_____

City/St/Zip:_____

Phone Number:_____

Please forward any of the following information that you have: x-rays, probing depth chart, charting and photographs to Dr. David LeMay.

I Hereby give you permission to release any and all of my dental records to Dr. LeMay.

_____ _____

Patient Signature (parent if a minor) Date

If records are digital, please email to :

davidlemaydds@gmail.com

Or mail to:

Dr. David LeMay, DDS
1259 Asheville Hwy.
Sylva, NC 28779