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Record Release/ Transfer

Patient's Name:

Requesters Name:

Patient's Date of Birth:

Current Phone Number:

I, \_\_\_\_\_, \_\_\_\_\_, grant permission to have dental records transferred and released from Smile Solutions by Emmi Dental Associates to: \_\_\_\_\_,

TRANSFERRING OFFICE

OFFICE EMAIL

Reason for transferring:

Additional information:

X

Signature

Date

- A copy of your current state issued identification must accompany this form
- Please allow 48 hours from date returned for records to be forwarded.
- We will be happy to forward your most recent radiographs that are less than 5 years old.