Release form to transfer dental x-rays and records to:
Lang Dental Group
543 Long Pond Road
Rochester, NY 14612
info@langdentalgroup.com (DIGITAL COPIES PREFERRED)
Phone: (585) 227-4190
Fax: (585) 227-4400

Previous Dental Practice: _____
Previous Dentist Address: _____
Previous Dentist Phone # and email: _____

Patient Name: _____

DOB: _____

This is a formal request to have my dental x-rays transferred to Lang Dental Group

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You have my permission to release any pertinent information, and x-rays that my new dental office may need.

_____

Signature of Patient, Parent, or Guardian **Date**

Name and Date of Birth of every family member you would also like x-rays transferred for (please print):
1)_____2)_____
3)_____4)_____
5)_____6)_____

Reason for Leaving (optional):