DR. ANTONINO BARBARO
FAMILY & COSMETIC DENTISTRY

Dental Records Release Form

Patient Name to Transfer: _____ D.O.B. _____ Phone: _____

If more than one patient;

Name: _____ D.O.B. _____ Phone: _____

Name: _____ D.O.B. _____ Phone: _____

Name: _____ D.O.B. _____ Phone: _____

Dentist or Practice Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

You are hereby requested and authorized to release all Protected Health Information in the form(s) of **Records, Radiographs, and Treatment Notes** or other information concerning the patient(s) listed above.

_____ _____

Patient Signature/Legal Guardian Date

Please mail to: Dr. Antonino Barbaro
1071 State Rt. 3 North
Gambrills, MD, 21054

-Or-

If records are digital, please email to:
receptionist@drbarbaro.com
Office contact number 410-721-8777