# Gregory S. Brya, DDS, PLLC

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## Record Release / Access Form: To Another Office

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** * _____

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Records to Release/Access:** *

◯ FMX or Bitewing (No Charge) ◯ Treatment Information (Fees will apply)

I authorize the release of dental records and X-rays from the office of Gregory S. Brya, DDS, PLLC of the above patient(s) to:

New Dentist Information:

**Name:**

_____

_____

**Address:**

_____

_____

**Phone Number:**

_____

_____

**E-Mail Address:**

_____

_____

**Fax Number:**

**Patient Information:**

**Name: ***

Signature of patient, parent or guardian (responsible party):

Signature _____ **Date** _____

**Relationship to Patient: ***

☐ Spouse ☐ Child ☐ Parent ☐ Guardian ☐ Other

**Date: *** _____

**Response Date:** _____