Advanced
Family Dental

Release of Records Form

____ Yes, I _____, authorize Dr. Roger Bussan, DDS to transfer my records to Advanced Family Dental for my future dental needs.

_____ No, I do not wish to continue my future dental needs with Advanced Family Dental. Please forward my records to the Dentist listed below.

_____
Name of Dentist

_____
Street Address

_____
City State Zip Phone Number

_____ _____
Patient or Guardian's signature Date