TARA KAUR DDS
& ASSOCIATES

DENTAL RECORDS RELEASE

Previous dentist: ____________________

Address: ____________________

Telephone/Fax: ____________________

Email: ____________________

I authorize and grant full permission to release to Tara Kaur, DDS, PLLC my complete Dental Record including radiographs, periodontal charting, outstanding treatment plans, appropriate correspondence from dental specialists and all dental materials testing results for the patient(s) listed below:

First and Last Name:	Date of Birth:

Patient/Guardian Signature(s): ____________________

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Date: ____________________

Our preferred method of communication is email: **smile@tarakaurdds.com**. If you are unable to electronically transfer dental records, please mail them to our dental clinic.