



**Patient Release of Records**

Name of previous dental office: \_\_\_\_\_

I, \_\_\_\_\_, authorize the release of my records to Timberlane Dental Group.

**Please email dental records and radiographs for the following patient(s) to [mailbox@timberlanedental.com](mailto:mailbox@timberlanedental.com) as soon as possible. Thank you.**

Patient Name (print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Patient or Parent/Guardian)

60 Timber Lane  
South Burlington, VT 05403  
Phone 802-864-6881  
Fax 802-264-6938

1127 North Avenue  
Burlington, VT 05408  
Phone 802-862-0770  
Fax 802-652-0742

5070 Shelburne Road  
Shelburne, VT 05482  
Phone 802-985-9797  
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7 Carmichael St.  
Essex Junction, VT 05452  
Phone 802-878-8348  
Fax 802-872-1828