WILLIAMSBURG CENTER for Dental Health℠

Stacey Sparkman Hall, D.D.S

Records Release Form

I, _____, authorize Williamsburg Center for Dental Health to request the following records from my previous dentist.

Previous Dentist: Name: _____

Address: _____

City, State: _____

Phone: _____

Fax: _____

Please note that Williamsburg Center for Dental Health is requesting the following records:

- All x-rays from the past five years
- All perio readings
- Recommended treatment and treatment plans

_____ _____

Signature Date

*Note to patients: Please send this form back either by fax to 757.565.6307 or scan and email to williamsburgdentalhealth@hotmail.com before your appointment.

*Note to doctor: Williamsburg Center for Dental Health is a chartless office and would prefer that the above records be sent via email to williamsburgdentalhealth@hotmail.com. Records may also be sent to the below address.