Cherryl A Davis, DDS PA
316 Commerce Ave
Morehead City NC 28557
coastalcarolinasmiles@gmail.com
(252) 247-4900
(252) 247-4935 – fax

RECORDS RELEASE:

I, _____, do hereby request that my dental records be transferred to
(Please print name)
the office of Cherryl A Davis, DDS PA as of this date.

I am authorizing this request for these additional family members:

_____ _____
Patient name relationship

_____ _____
Patient name relationship

_____ _____
Patient name relationship

Signed:_____

Date_____

Please indicate name, phone number of dentist office from which you are requesting transfer:

Dr._____

Address:_____

Phone #:_____