Charm Pediatric Dentistry, LLC
Dentistry Exclusively for Infants, Children, and Teens
1040 Dekalb Pike
Blue Bell, PA 19422
Tel: (610) 277-4811
Fax: (610) 277-4896

Date: _____

Request for Release of Dental X-rays and Records for:
1._____
2._____
3._____

As per your request, please sign, date and indicate below to whom your dental records should be sent to.

Dr. _____

Street: _____

City, State, Zip Code: _____

Upon receipt of this completed letter, we will be happy to forward the records. Thank you for your past association with our office. Should your circumstances change in the future, please consider our practice again! Thank you.

Sincerely,
Charm Pediatric Dentistry, LLC

Signature: _____

Date: _____

X-ray release forms or any files that need to be transferred will take up to 48 hours. Please Plan to request and Submit Accordingly. Thank you