

Great Oaks Dentistry
15930 Great Oaks Drive
Suite A-100
Round Rock, TX 78681
512-255-3800

I, _____ give permission to
Great Oaks Dentistry to release dental records to:

Name: _____

Phone #: _____

E-Mail: _____

I am requesting the records for the following patients:

Please initial by the option that you choose:

_____ Option #1: I understand that these records can be sent directly to my
new dental office at **no charge**, if that office accepts e-mailed digital x-rays.
(Please call to make sure your new dental office can accept this option)

OR

_____ Option #2: I understand that I can pick up my records (in disk
format) at Great Oaks for **\$25**. (Due at the time of pick up)

Signature _____ Date _____