



ELEVATE  
dental wellness

711 East Valley Road, Suite 201A  
Basalt, CO 81621  
Phone (970) 279-5647  
[frontdesk@elevatewillits.com](mailto:frontdesk@elevatewillits.com)

Dental Records Release Form

Patient Name to Transfer: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Other Family Members to Transfer:

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Name: \_\_\_\_\_ DOB \_\_\_\_\_

Previous Dentist or Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please forward any of the following information that you have: x-rays, probing depth chart and dental record charting to Elevate Dental Wellness.

I hereby give you permission to release any and all of my dental records to Elevate Dental Wellness.

\_\_\_\_\_ Date \_\_\_\_\_

Patient Signature (parent if a minor)

If records are digital, please email to:

[frontdesk@elevatewillits.com](mailto:frontdesk@elevatewillits.com)

Or mail to:

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