



ROSE DENTAL GROUP

I, _____ give permission to Rose Dental Group to release dental records to:

Dental Office 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 Rose Dental for **\$25**. (Due at the time of pick up)

Signature _____ Date _____

11615 Angus Rd., Ste. 210
Austin, TX 78759
512.795.9643 Phone
512.795.9959 Fax

893 N. IH-35, Ste. 200
Round Rock, TX 78664
512.310.9374 Phone
512.244.3954 Fax

6211 W. William Cannon, #A
Austin, TX 78749
512.288.4447 Phone
512.288.4774 Fax