

# Request For Dental Records to be sent to :

## St. Mary's Dental

Gina F. McCray, D.D.S., P.A.  
28160 Old Village Road  
Mechanicsville, MD 20659  
301-884-3248

I, \_\_\_\_\_, authorize \_\_\_\_\_ to furnish a  
(Patient Name) (Previous Dentist's Name)  
copy of dental records to **St. Mary's Dental** for the following Patients:

Name:	Date of Birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I release you from legal responsibility or liability that may arise from this authorization.

Thank You!

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Previous Dentist Name and Address:

\_\_\_\_\_  
\_\_\_\_\_

Please email digital radiographs to [stmarysdental@rcn.com](mailto:stmarysdental@rcn.com) or mail radiograph copies to:

St. Mary's Dental  
Attn: Gina McCray, DDS  
28160 Old Village Road  
Mechanicsville, MD 20659  
FAX: 866-219-6469