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 or mail radiograph copies to:

St. Mary's Dental
Attn: Gina McCray, DDS
28160 Old Village Road
Mechanicsville, MD 20659

FAX: 866-219-6469

Submit