McCormick Family Dentistry
J. Beaux McCormick, D.M.D
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228-868-1942
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Records Release

I, (patient) _____
(date of birth) ____/____/____, authorize the release of dental records and medical records from Dr. _____ relevant to dental treatment or copies of such and request that they be transferred to:

J. Beaux McCormick, D.M.D
3506 Washington Ave. Suite I
Gulfport, MS 39507
Email: Beaux2008@gmail.com

Please email if possible, if not please mail within 5 days of receipt of fax. Thank you
**please include copy of progress notes, periodontal charting and radiographs

_____
Signature of Patient/ Guardian

_____
Date