KINCAID & PURVIS
Family Dentistry

REQUEST TO RELEASE/TRANSFER

DENTAL RECORDS

I, (name/date of birth)_____, hereby request the release and/or transfer of my dental records and radiographs.

William I. Kincaid, III, DDS, PLLC
James T. Purvis, DDS
635 McCarthy Blvd.
New Bern NC 28562
252 636-0011 fax 252 288-5715
Email to: scheduling@kincaidandpurvis.com

To/From_____

Address:_____

Phone number:_____ Fax number:_____

Signature:_____ Date: _____/_____/_____

Please list all patients by name and date of birth covered by this release:

. _____

. _____

. _____

. _____

. _____