

**RECORD RELEASE  
TRANSFERRING FROM ANOTHER OFFICE**

DENTAL OFFICE NAME: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**PLEASE RELEASE MY X-RAYS AND ALL CLINICAL NOTES TO:**

JEFFREY M. COLLURA, DMD  
7 BURNHAM STREET  
TURNERS FALLS, MA 01376  
413-774-6553

**DIGITAL X-RAYS & CLINICAL NOTES SHOULD BE SENT TO:**

**info@turnersfallsdental.com**