



Calvert Dentistry
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I _____ (printed name) Hear by request my records or records of my minor child.

Records requested are for _____ (Self or Name of Minor child).

Sent From: (Name, address, area code and phone number of dentist/ person sending records)

Send to:

I understand there may be an administrative fee applied for photo copying pages and/or duplicating x-rays.

The fee of \$_____ was discussed with me and I agree to pay the fee upon record request.

_____	_____	_____
Patients Printed Name	Patients Signature (Parent if minor)	Date