CENTRAL PARK
DENTAL

DR. KARLYN TAYLOR, DDS
303-388-2400

Dental Records Transfer Request

Patient Name: _____ Date of Birth: _____

Previous Dentist or Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Phone Number: _____

Please forward any of the following patient records: x-rays, ledger, charting, and photographs to Central Park Dental.

I hereby authorize to release any and all of my dental records to Central Park Dental.

Patient or Guardian Signature: _____ Date: _____

If records are digital, please email to: info@cpddenver.com

Or mail to:
Central Park Dental
2373 Central Park Blvd, Suite #304
Denver, CO 80238