HARRY E. RAMSEY, JR., D.D.S., P.C.
HARRY E. RAMSEY, III, D.D.S.
136 E. Little Creek Road, Norfolk, VA 23505

October 6, 2026

Dear Valued Patient,

I am writing to let you know that I will be closing my dental practice, effective November 8, 2026. The location where we have practiced is no longer available to us, which has forced us to make the difficult decision to close. The last day I will see patients is Thursday, November 5. I feel very fortunate to have practiced dentistry with such a wonderful group of patients. I have enjoyed our friendship, and it has been my pleasure to meet the dental needs of you and your family.

If You Are in the Middle of Treatment
If you have dental treatment in progress — a temporary crown, a pending laboratory case, an implant, or any other work that is not yet finished — please call the office right away, before the closing date, so that arrangements can be made either to complete your care or to transfer it to another dentist.

Dental Records
Your dental records will be securely maintained in accordance with Virginia law and HIPAA regulations. Effective as of November 8, 2026, your dental records will be transferred from our practice location at 136 E. Little Creek Road in Norfolk, Virginia, to the following address:

Harry E. Ramsey, III, D.D.S.
507 High View Road
Farmville, Virginia 23901

I will continue to serve as the custodian of your dental records after the practice closes unless I notify you otherwise or you request the transfer of your records as hereinafter provided. At your written request, your records or copies of them will be provided to you, or sent to any other licensed dentist of your choosing. The enclosed form is provided for your convenience; you are welcome to use it, but you are not required to do so. There may be a small charge not to exceed the actual cost of copying and mailing your records.

Continued Care
We encourage you to establish care with another licensed dentist to ensure continuity of your dental treatment. We recommend our friends:

- Dr. David Marshall, at (757) 489-4221 or marshallxrays@outlook.com
- Or a dentist affiliated with Atlantic Dental Care, PLC, via https://www.atlanticdentalcare.net/

Questions
If you have questions regarding this closure or the process for obtaining your dental records, please contact us at 757-489-1811 (Office) or email hramseydds@gmail.com.

I wish you and your family all the best!

Sincerely,

Harry E. Ramsey, III, D.D.S. 757-754-4235 (Cell)

Enclosure: Dental Records Request Form

DENTAL RECORDS REQUEST & AUTHORIZATION FORM

Complete the following form if you would like a copy of your dental record or if you would like them transferred to a provider of your choice.

Patient Information

- **Patient Name:** _____
- **Date of Birth:** _____
- **Phone Number:** _____
- **Email (optional):** _____

If the patient is a minor or legally incapacitated (please attach documentation of your authority):

- **Name of Parent/Legal Representative:** _____
- **Relationship to Patient:** _____

Records Requested (Please check all that apply)

☐ Complete dental record

☐ Treatment notes / clinical records

☐ Radiographs (X-rays)

☐ Billing and insurance records

☐ Other (please specify): _____

Delivery Method (Select one)

☐ Mail records to patient (address below)

☐ E-Mail records to patient _____(email address)

☐ Mail records directly to a new dental provider (address below)

☐ E-Mail records to new provider _____(email address)

Mailing Address or New Provider Information:

Name: _____

Address: _____

_____

_____

DENTAL RECORDS REQUEST & AUTHORIZATION FORM

Complete the following form if you would like a copy of your dental record or if you would like them transferred to a provider of your choice.

Patient Request for Records

I am requesting the dental records described above. I understand that my records will be provided in accordance with the above request, and that there will be a small charge for copying and delivery of my records, not exceed the actual cost thereof.

Patient or Legal Representative Signature: _____

Printed Name: _____

Date: _____

Submission Instructions

Please submit this completed form in person or to the records custodian:

Harry E. Ramsey, III, 507 High View Road, Farmville, VA 23901

or email the completed form to hramseydds@gmail.com

For Office Use Only

Date Request Received: _____

Date Records Released: _____

Method of Release: _____

Released to Provider or Patient: _____

Address to which Records Were Released: _____