WOLKEN

FAMILY DENTAL

Release / Transfer of Dental Records

Patient Name(s): _____

_____

Date(s) of Birth: _____

_____

I authorize Dr. _____, located at

_____ to release copies of my dental records (including Bitewing X-Rays less than 12 months old, FMX or Panoramic X-Rays less than 36 months old) to Dr. _____.

Please fill out the following information about your new dentist:

Name: _____

Phone #: _____ Fax #: _____

Address: _____

_____

_____

E-mail address: _____

_____ _____

Signature of patient, parent, or legal guardian Date

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