SMITH
FAMILY DENTISTRY

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Authorization for Transfer of Dental Records & Xrays

Name of Patient: _____

Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, _____, hereby authorize the release of dental records or knowledge concerning the dental health of the patient(s) listed above. I further request that these records be transferred to

_____.

Patient or Guardian Signature: _____

Date: _____