Record Release to Another Office

Date: _____

New Dental Office: _____

Address: _____

City: _____ State: _____ Zip: _____

I request and authorize the release of dental records and x-rays to dental treatment, or copies of such, and request they be transferred to: _____

Patient's name:_____

Date of Birth: _____

Signature: _____

If patient is a minor, relationship to patient: _____

315 West Kemper Road Cincinnati, Ohio 45246 513.772.8840