

Request for Records Transfer

Dental Office/ Dentist with Dental Records:

Address:

Phone & email:

Patient Name:

Last

First

MI

Preferred Name

Address:

City

State

Zip Code

Phone:

Home

Work

Ext

Mobile

Best time to call:

I hereby authorize release of my dental records, current radiographs and copies of such and request that they be transferred to Dr. Michelle R. Olmstead and or associates at Northpointe Family Dentistry .

Signature: _____

Date:

Response Date: