

Authorization for the Release of Dental Records and X-rays

Date: _____

Transfer records from:

(Previous dental practice name)

(Previous dental practice address)

(Previous dental practice city, state, zip)

I, _____, DOB _____,
(Your name)

request the release of my dental records to Dr. Kathy T Knox DDS at Otego Family Dental P.C..

**Please forward records to the address below. Please send radiographs (x-rays) via eMail to
Records@OtegoFamilyDentalPC.com**

I specifically request that you release copies of current X-rays and treatment notes.

Thank you for your time and cooperation with this matter.

Patient's Signature: -----