REQUEST FOR TRANSFER OF RECORDS

Date of Request: _____

As Patient, Parent or legal guardian of the individual(s) listed below, I hereby authorize and request the copying and release of dental record(s). Including the sequential treatment plan, doctor's progress and treatment notes, all radiographs (x-rays) taken in the past year and full mouth series/panolipse films completed in the past three years from the date of this request.

Patient's Name(s):

1._____ DOB_____

2._____ DOB_____

3._____ DOB_____

4._____ DOB_____

5._____ DOB_____

6._____ DOB_____

Please forward the dental records for each of the above named patient(s) within a week of the above date to:

Smiles Unlimited
Eric Runyon, D.D.S., D. ABDSM
103 Congress
Belton, MO 64012
or
Email digitals to: info@beltonsmiles.com

Signature: _____

Print Name: _____

Thank you in advance for your prompt response to this request.