

**Urbandale Family Dentistry P.C.  
Thomas R Tippins D.D.S.  
Comprehensive Family Dentistry**

**PATIENT RECORD TRANSFER**

Date: \_\_\_\_\_

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I \_\_\_\_\_ hereby request that my  
(Signature Required)

**Dental Records/Radiographs be released:**

**TO [ ] / FROM [ ]**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Address** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please call or write our office with any questions.**

**3124 104<sup>th</sup> Street**

**Urbandale, IA 50322**

**(515) 276-7925 - Fax (515) 276-7139**

**office@urbandaledentists.com**

**(Members of eDosea)**

(Call us for a share code - required for transfer of our patient records)