Authorization for Transfer of Patient Information

Please let this notice serve as my request for transfer of my dental records. I hereby authorize

Dr. Name DB Dentistry
Address 111 N. Wabash Ave., Suite 1921
City/State Chicago, IL. 60602
Phone/Fax 312-332-4424/ 312-332-4423

To release my dental record/radiographs to:
Or
Can be emailed to:

Patient: _____
Date of birth: _____
Signature:_____