Aberdeen
DENTAL ASSOCIATES

Aberdeen Dental Associates
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Authorization for Transfer of Dental Records and X-rays

Name of patient:_____

Patient's DOB_____

Address:_____

City:_____State:_____Zip:_____

Additional family members to be included:

Name:_____DOB:_____

Name:_____DOB:_____

Name:_____DOB:_____

I, (print patient or parent/guardian name) _____ hereby authorize the release of dental records or knowledge concerning the dental health of the patient(s) listed above.

I further request that these records be transferred to:_____

Signed (patient or parent/guardian signature):_____

Date:_____