RELEASE OF DENTAL RECORDS

From: _____

_____

_____

Patient Name:_____

Date of Birth:_____

Due to the privacy of information act, I hereby sign this release for the above mentioned office to transfer copies of my dental records and any current x-rays to my new dental services provider:

To: Malinoski & Associates, DDS
717 Health Parkway
Three Rivers, MI 49093
Ph (269)279-7876
Fax (269)279-5823

This also confirms my permanent transfer to the above mentioned office.

Signed:_____

Relationship to patient (if patient is a minor):

_____

Date:_____

Office use only:

Date release sent: _____ Staff Initials:_____