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KRAMER DENTAL
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Paul J. Kramer, DMD
James K. Kramer, DMD

AUTHORIZATION TO RELEASE OR REQUEST DENTAL RECORDS

Patient Information
Patient Name: _____
Date of Birth: _____
Phone Number: _____

____ TRANSFER TO Kramer Dental
I authorize my previous dentist or dental office to release my dental records, including radiographs (x-rays), treatment notes, and any other pertinent information, to Kramer Dental.
Records to be relased from:
Practice Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Email:_____

____ TRANSFER FROM KRAMER DENTAL
I authorize Kramer Dental to release my dental records, including radiographs (x-rays), treatment notes, and any other pertinent information, to the following recipient:
Records to be released to:
Practice/Recipient Name: _____
Address:_____
City/State/Zip: _____
Phone: _____Email: _____

Patient/Parent/Guardian Signature:
_____
Date: _____

Relationship to Patient (if applicable): _____

Response Date: _____