

**Sein H. Siao, D.M.D. and Associates
14 Common Street
Wrentham, MA 02093
(508)384-8136**

REQUEST TO COPY AND TRANSFER DENTAL RECORDS

Patient Name: _____ **Date:** _____

Family Members including _____

I request my (or my families) dental records and/or x-rays be transferred to:

Name: _____

Address: _____

Email: _____

I give the office of Sein H. Siao, D.M.D. and Associates permission to release this information.

Patient Signature: _____ **Date:** _____