Horvath Family Dentistry

We Love to Make You Smile

Authorization for Transfer of Dental Records

Name of Patient: _____

Patient's D.O.B: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

I, _____, 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:

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Fax: _____

Signed (patient or guardian signature): _____

Date: _____

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