# RECORDS RELEASE/TRANSFER REQUEST

To:

_____
(Dentist Name)

Address _____

_____

City _____ State _____ Zip _____

I hereby authorize the release of my records and radiographs (or copies of such) and request they be transferred to:

Campbell S. Delk, D.D.S., P.C.
Richard H. Wood, D.D.S.
4440 Springfield Road
Suite 104
Glen Allen, VA 23060
(804) 747-9511

Email digital images to: info@wood-delk.com

Print Patient Name _____

Print Patient Address _____

Patient Telephone _____

Patient Signature _____ Date _____