DENTAL ASSOCIATES OF WALPOLE

Family ◦ Specialty ◦ Care

Transfer of Dental Records/X-rays

Date of Request: ______________________________

Transfer of Records **2nd Opinion**

Reason for Transfer: ____

Release:

Dental records & x-rays Only x-rays

Orthodontic Records & x-rays ***(*additional form required***)

Patient Name:

1. ____ DOB: ________________________
2. ____ DOB: ________________________
3. ____ DOB: ________________________
4. ____ DOB: ________________________
5. ____ DOB: ________________________

Pick up Records *Contact Phone Number: _________________________________

E-mail (X-rays Only) ____

Mail Records to: ____

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Signature (*patient, parent or legal guardian*): ____

Please Print Name: ____

By my signature above, I am authorizing Dental Associates of Walpole to release any records, including any radiographs that my family (patients listed above) or I may have at this office.