

From the office of:
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Patient Request for Transfer of Dental Records

Name: _____ **Date:** _____

Transfer records for the following patients:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Transfer To: _____ **Transfer From:** _____

Reason for leaving: _____

Patient Signature: _____ **Date:** _____