REQUEST FOR THE TRANSFER OF DENTAL RECORDS AND X-RAYS

INFORMATION TO BE DISCLOSED:

PATIENT INFORMATION:

Full Name

Street Address

City. State, Zip Code

/ /

Date Of Birth

Phone Number

☐ Radiographs (X-rays)

☐ Other (Specify):

By signing below, I authorize the practice of

UP VALLEY
PEDIATRIC DENTISTRY
KIM NICHELINI, DMD • ANGELINA RING, DDS

Up Valley Pediatric Dentistry
176 Main Street #A
St. Helena, CA 94574
ph 707.968.5144
fax 707.302.5298

to release records or knowledge concerning my dental health to:

☐ Given directly to me

☐ Sent directly to a dental office

Practice Name

Address

City/State/Zip

Telephone

Fax

Email

Parent or Guardian's Signature

Date