ATLAS WALK
DENTAL & ORTHODONTICS

Authorization for Transfer of Dental Records and X-rays

Name of Patient: _____

Patient's DOB: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Additional family members to be included:

Name: _____DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____DOB: _____
Name: _____DOB: _____

I, (print patient or guardian name) _____ , hereby authorize the release of dental records or knowledge concerning the dental health of the patient(s) listed above.

From:
Office Name / Provider: _____
Address: _____
Phone: _____
Email: _____

To:
Office Name / Provider: _____
Address: _____
Phone: _____
Email: _____

Name: _____

Signed (patient or guardian signature): _____

Date: _____