



DATE; _____

I, _____ hereby request the release and transfer of any pertinent dental x-rays and records, or copies of such, from:

TO: Caring Hands Dental Clinic

Patient's name – *printed*

Signature of parent, guardian or patient

2209 Jefferson St., Ste 101A, Alexandria, MN 56308
320-815-5711 email: frontdesk@caringhandsdc.org
www.caringhandsdentalclinic.com