Caring Hands
Dental Clinic
West Central Dental Resources, Inc.
A Community Dental Access Clinic

DATE; _____

I, _____ hereby request the release and transfer of any pertinent dental x-rays and records, or copies of such, from Caring Hands Dental Clinic to;

Dental clinic name_____
address_____
_____
phone_____
email_____

_____
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