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* *DOB*

_____
Signature of parent, guardian or patient

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320-815-5711 caringhandsdc@gctel.net
www.caringhandsdentalclinic.com