



I, _____ am requesting for the release of patient records to be transferred from Blakeslee Dental for the following patients:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Address of practice records are being requested to be transferred to:

Office Phone Number: _____

Office Email Address: _____

Signature: _____ Date: _____

