I, ______________________________am requesting for the release of patient records to be transferred to/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: __________________