



GibbsDentistry

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Today's Date: _____

AUTHORIZATION TO RELEASE TRANSFER OF DENTAL RECORDS

I request the release and/or transfer of dental records and radiographs.

Print Patient Name _____

Patient DOB _____

Patient or Guardian Signature _____

Previous Dentist _____

Address _____

Phone Number _____

E-Mail Address: gibbsinfo@gibbsdentistry.com