KRENGEL DENTAL RELEASE OF RECORDS

Patient Name: _____

Patient Birthdate: _____

Patient's Phone Number: _____

Patient's Address: _____

City:_____ State:_____ Zip:_____

Name of previous dental office: _____

Their Phone Number: _____

Their location:_____

By signing below, the patient give us permission to have his/her records copied and picked up or sent to the indicated party below.

Signature:_____

Patient's authorization signature (legal guardian or parent if patient is under 18). Signature is valid for 1 year but additional requests for copies or large volumes are subject to additional fees. Proof of ID may be requested when picking up copies in person.

Please email files to: office@krengeldental.com

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