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 gives us permission to have his/her records requested from their previous office as indicated above.

Signature: _____

Patient's authorization signature (legal guardian or parent if patient is under 18).

Please email files to: office@krengeldental.com

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