O'Rourke Family and Cosmetic Dentistry

Patients name:_____ Today's Date_____

Radiograph Request/Dental Records Transfer form

Previous Dental Practice Name:

_____

Phone_____

I hereby authorize you to release my radiographs/Dental records to the below named dental practice:

O'Rourke Family and Cosmetic Dentistry, PC

757 Peachtree Parkway Cumming, GA 30041

770-888-6285/ www.orourkefamilydentistry.com

Submit digitally to Info@mycummingdentist.com

Thank you for your prompt attention to this matter.

Patient's printed name:_____**DOB**_____

Patient, Parent or Guardian Signature:_____

(If under 18, Parent/Guardian signature required)