O'Rourke Family and Cosmetic Dentistry

Today's Date:_____

Patient's name: _____

Radiograph Request/Dental Records Transfer Form

Previous Dental Practice Name:_____ Dentist phone:_____

Previous Dentist's Address:_____

City: _____State: _____ Zip:_____

Previous Dentist's email/website:_____

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

O'Rourke Family and Cosmetic Dentistry, PC
757 Peachtree Parkway
Cumming, GA 30041
770-888-6285
orourkefamilydentistry.com
Submit digitally to adminorourke@bellsouth.net

Thank you for your prompt attention to this matter.

Patient's printed name:_____

Patient, Parent or Guardian Signature:_____
(If Under18, Parent/Guardian Signature Required)

Patient's Address:_____

City:_____State:_____ Zip:_____

Phone:_____