

RECORDS TRANSFER REQUEST

DATE: _____

TO: _____
Name of Previous Dentist or Clinic

ADDRESS: _____

**I hereby authorize the release of my dental records
and/or x-rays, and request that they be forwarded to:**

**Columbia Center For Dentistry
C. Bradley Miller, DDS, PC
1506 Chapel Hill Road
Columbia, MO 65203**

Print name of patient

Date of Birth

Patient Signature