

JOHN P. MEYER, DDS

The Gentle Dentist

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General Dentistry

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Authorization for Transfer of Dental Records and X-rays to Dr. Meyer's office

Name of patient: _____

Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, (print patient or parent/guardian name) _____,
hereby authorize the release of dental records or knowledge concerning the dental health of the
patient(s) listed above.

I further request that these records be transferred to Dr. John P. Meyer at the above address.

Signed (patient or parent/guardian signature): _____

Date: _____