PATIENT AUTHORIZATION FOR RECORD RELEASE

For transfer of ☐ records **TO** Winn Family Dentistry

For transfer of ☐ records **FROM** Winn Family Dentistry

I, _____ (print name), hereby request the disclosure of information and/or xrays from my dental records on file with your office.

Patient Signature _____ Date _____

Patient Date of Birth _____

Previous/Forwarding Dental Office/ Dentist _____

****Please email x-rays to admin@winnfamilydentistry.com****

2849 County Hwy I
Chippewa Falls, WI 54729
Phone: 715-723-0287
Fax: 715-723-2091