All Smiles dental care

TRANSFER OF RECORDS

201 West 2nd Street
Minneapolis, KS 67467
Ph.#785-392-2194
wecare@allsmilesks.com

I hereby request and authorize that all my dental records be release (including any x-rays)

_____	_____
Patient	Birth Date
_____	_____
Patient	Birth Date
_____	_____
Patient	Birth Date
_____	_____
Patient	Birth Date
_____	_____
Patient	Birth Date

Records Released from: _____

Records sent to: wecare@allsmilesks.com

Signed _____

Address _____

_____

Phone _____

Date _____