

PATIENT REQUEST FOR TRANSFER OF RECORDS

Patient's Name and Address:

NAME: _____

ADDRESS: _____

EMAIL: _____

Transfer records to:

MARLENE FEISTHAMEL, DDS, PC

Feisthamel Family Dentistry

5469 S. State Hwy FF, Battlefield, MO 65619

417-447-5180

I request and give permission to transfer any and all dental records to the above named dentist.

Signed: _____

Dated _____