Jeff Clark D.D.S.
5990 SW 28th St.
Topeka, KS 66614
785-273-2565

I, _____, hereby request and
(Patient or Guardian)

authorize_____ to turn over my dental
(Practice or Dentist Name)

radiographs to Dr. _____ or to forward a copy to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be transferred to Dr. _____ on_____. By
(date)

authorizing this transfer, I understand that I am not impairing Dr._____ right of access to my records, when necessary, during the time period in which I was under his care.
(doctor that is copying or transferring records)

Name_____
(Name of new dentist, specialist, consultant, patient, attorney, insurer, etc.)
Street Address_____

City_____State_____Zip_____

Telephone Number_____

Signed _____Date_____
(Patient of Guardian)