

William B. Munn, D.D.S.



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RECORD TRANSFER REQUEST

Please provide me with X-Rays for:

_____	Date of Birth: _____
_____	Date of Birth: _____
_____	Date of Birth: _____
_____	Date of Birth: _____

I understand that my actual dental records, by law, belong to my dentist. I understand that the information in the records belongs to me. I agree to accept copies of such records and that in signing this release I am terminating the doctor patient relationship.

Please give these X-Rays to **Dr. William B. Munn. D.D.S**

Print Name: _____ Date: _____

Signature: _____

Print Name: _____ Date: _____

Signature: _____

Parents sign for minor children under 18 years of age.
Each person over 18 years of age must sign the release on their own behalf.