William B. Munn, D.D.S.

3890 Old Williamsburg Road
Sandston, VA 23150
Tel: 804-328-2200 • Fax: 804-328-0528

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.