Authorization for Transfer of Dental Records and X-rays to Dr. White's office

Name of patient: _____

Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, (print patient or parent/guardian name) _____,

hereby authorize the release of dental records or knowledge concerning the dental health of the patient(s) listed above.

I further request that these records be transferred to Dr. Ben White DDS at the address listed below.

Signed (patient or parent/guardian signature): _____

Date: _____

Dr Ben White DDS
1108 N. 12th Ave. Suite C, Pensacola, FL 32561
Phone: (850)912-8877 Fax: (850)912-8932