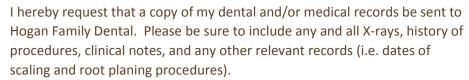
REQUEST FOR TRANSER OF PATIENT RECORDS





Patient's Name (Printed): Patient's Date of Birth: Name of Parent/Guardian: Relationship to Patient: Previous Dentist(s): The patient agrees hereby to cover the cost of copying or transferring said records and x-rays. Patient / Guardian Signature: Witness to Signature:			
		Date of Request:	
		NOTES:	
		Please send physical or digital records to:	
		Hogan Family Dental	T: (406) 234 – 2926
		1820 Valley Drive East	F: (406) 234 – 3552
		Miles City MT 59301	E: <u>hfdental@midrivers.com</u>

Please feel free to contact Hogan Family Dental with any questions you may have. Thank you in advance for your prompt reply.