REQUEST FOR PATIENT X-RAYS AND RECORDS

Patient Giving Consent

Name:_____

Address: _____

Telephone: _____

Dentist Office to Send Request:

_____

Clinic Requesting Records

Glacier Dental Group, David C. Keim, DDS
1228 Whitefish Stage Road
Kalispell, MT 59901
752-8081 / fax 752-8083

Authorization

I hereby authorize the release of any x-rays/records pertaining to my account to be transferred to the clinic of David C. Keim DDS. If there is any special information that should be known by this office, send the information as well.

Date: _____

Patient Signature: _____

OR
Authorize Signature:_____

Relationship to patient _____