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## REQUEST FOR DENTAL RECORDS

IN ORDER TO PROTECT THE CONTINUITY OF TREATMENT, WE WOULD APPRECIATE THE TRANSFER OF A COPY OF DENTAL RECORDS AND ANY CURRENT DENTAL RADIOGRAPHS FOR THE BELOW-MENTIONED PATIENT. THANK YOU IN ADVANCE FOR YOUR PROMPT COOPERATION

### RECORD TRANSFER REQUEST FOR:

PATIENT NAME:

DOB:

ADDRESS:

BY SIGNING BELOW, I CONSENT FOR MY DENTAL TREATMENT RECORDS AND/OR X-RAYS TO BE TRANSFERRED BY EMAIL TO OFFICE@DRLAMDENTISTRY.COM

PRACTICE NAME: DR. COURTNEY J. LAM, DMD  
PRACTICE ADDRESS: 244 ADELIA ST, MIDDLETOWN, PA 17057  
PRACTICE PHONE NUMBER: (717) 944 3311

SIGNATURE:

DATE: