WEIMERSKIRCH
FAMILY DENTAL LLC

Authorization to request a transfer of dental records and radiographs

This patient is a(n): ☐ Adult (18 years or older) ☐ Minor Child ☐ Dependent Adult

Birthdate: _____

Telephone: _____

Patient Name: _____
First Middle Last

_____
Address City State Zip

- **Preferred disclosure method:** ☐ mail ☐ fax ☐ pick up ☐ email
- **When to release the information:** ☐ immediately ☐ _____ (specify date)
- **Person or place to release records to:**

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

This authorization will automatically expire one year from the date of signature, unless specified with an earlier date:
_____
At that time, no express revocation shall be needed to terminate my request to transfer records, but understand that I may revoke this consent at any time by sending a written notice Weimerskirch Family Dental, LLC, 406 Wall St, East Dubuque, IL 61025. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting Weimerskirch Family Dental, LLC, 406 Wall St, East Dubuque, IL 61025.

_____ _____
Signature of patient or legal guardian Date

_____ _____
Name of legal guardian if other than patient Relationship to Patient