

Date: _____

To: Dr. _____

Telephone: _____

Dear Dr. _____,

Please transfer my dental records, including all radiographs and other diagnostic records to Dr. Satashia's office at the address indicated above on this letterhead.

Thank you very much.

Sincerely,

Patient's Signature

Printed Name

Names of minor dependents included in this request:

- 1). _____
- 2). _____
- 3). _____
- 4). _____