



DRS. MERLE, ZICHERMAN & ASSOCIATES
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 ADULT & COSMETIC DENTISTRY

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PATIENT RECORD TRANSFER AUTHORIZATION

PATIENT NAME: _____

DATE OF BIRTH: ___/___/___

TRANSFER TO: _____

DATE OF LAST EXAMINATION: ___/___/___

DATE OF LAST VISIT: ___/___/___

LAST X-RAYS: PANORAMIC ___/___/___ BITEWINGS ___/___/___

X-RAYS ENCLOSED: PANORAMIC ___ BITEWING ___ OTHER ___

COMMENTS:

I authorize the offices of Drs. Merle, Zicherman and Associates to duplicate and transfer my/my children's dental records.

Signature: _____

Name Printed: _____

Date: ___/___/___