RECORDS RELEASE/TRANSFER REQUEST

To: _____

(Dentist Name)

Address _____

City _____ State _____ Zip _____

I hereby authorize the release of my records and radiographs and request they be transferred to:

Campbell S. Delk, D.D.S., P.C.

4440 Springfield Road

Suite 104

Glen Allen, VA 23060

(804)747-9511

Email any digital images to: info@delkfamilydds.com

Print Patient Name _____

Print Patient Address _____

Patient Telephone _____

Patient Signature_____ Date_____