



Ann L. Hunsicker-Morrissey DMD, MAGD  
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### **Record Transfer Request**

Date \_\_\_\_\_

To: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby request the release of my records and x-rays or copies of such and request that they be transferred to:

**Hellertown Dental Group**  
Ann L. Hunsicker-Morrissey DMD, MAGD  
1213 Main Street  
Hellertown, PA 18055

**Or Email:** [Sandra@hellertowndentalgroup.com](mailto:Sandra@hellertowndentalgroup.com)

Print name of Patient \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_