1213 Main Street
Hellertown, PA 18055
610-838-0131
Fax # 610-838-1308

Record Transfer Request

Date _____

To: _____

Address _____ Email_____

City _____ State _____ Zip _____

Phone # _____ Fax#_____

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
1213 Main Street
Hellertown, PA 18055

Or Email: Xrays@hellertowndentalgroup.com

Print name of Patient _____

Date of Birth _____

Signature of Patient or Guardian _____