Golden Oak Dental Care
11345 N Port Washington Road
Mequon, WI 53092

AUTHORIZATION TO RELEASE RECORDS

Office that I/We request the release of information **FROM** is:

DR ____________________________________
(address) ________________________________
(city, zip) ________________________________
(phone #) ________________________________

I hereby authorize and request the release of records or copies of such records, including x-rays **(BWX two years old or less and panoramic or FMX three years old or less)**, dental/medical treatment and history to:

Stephan W. Klug, D.D.S., F.A.G.D.
Golden Oak Dental Care
11345 N Port Washington Road
Mequon, WI 53092

Signed: ____________________________________
(Parent or Parent/Guardian)

____
(Please Print Name)

Name of other family member's records to be transferred are:
(Please Print)

____________________ ____________________

____________________ ____________________

____________________ ____________________

Thank You