

**KIM A. MILLER, DDS, PA  
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**RECORDS RELEASE and TRANSFER REQUEST**

I, \_\_\_\_\_, (date of birth \_\_\_\_\_) do hereby authorize the office of Kim A. Miller, DDS, PA to release and transfer my dental records and any family members listed below (clinical notes, records and x-rays) to the person or office listed below:

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Records were picked up by: \_\_\_\_\_ Date: \_\_\_\_\_

Records were mailed on: \_\_\_\_\_

Mail To:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_