Deborah L King, DDS
2964 Peachtree Road NW
Buckhead Centre, Suite 340
Atlanta, GA 30305
404.239.9566

Request for Transfer of Records

TO: ________________________________

The undersigned, ____________________________________ hereby authorizes and requests _________________________________ (my former dentist) to transfer a complete copy of my patient chart, including but limited to, copies of any and all dental information, treatment notes and x-rays regarding the treatment rendered to myself or my child to **DEBORAH L. KING, DDS** at the following address:

Buckhead Dental Care, PC
2964 Peachtree Road, NW
Suite 340
Atlanta, Georgia 30305

Name of patient(s) for record transfer(s):

____

______________________________________ ____________
(Patient or Parent Signature) (Date)

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WITNESSS