Authorization to Transfer Records

This authorizes the office of _____
to send the following patients' records to Dr. Joseph F. Sepe.

Patient name: _____

Patient name: _____

Patient name: _____

Patient name: _____

Please send records to: **Joseph F. Sepe, DDS**
8507 S. 5th St., #A-101
Ridgefield, WA 98642
admin@pioneerdental.org

_____
Patient/Responsible Party

_____
Date

(08/2006)