Release of Records

Please complete and sign the following form, including the forwarding address, and return to Maria C. Hoekstra, DDS, PC.

PATIENT NAME: _____

DATE OF BIRTH: _____

FOR OFFICE USE

DATE OF LAST:

EXAM: _____ PROPHY: _____

BW: _____ PAN / FMX: _____

Upon receipt of this form, your records will be transferred to your preferred provider. You will become inactive in our system and will no longer receive recall requests, unless otherwise stated.

PATIENT SIGNATURE: _____

DATE: _____

PLEASE FORWARD FILMS TO THE FOLLOWING EMAIL:

_____

MARIA C. HOEKSTRA DDS, PC

MARIGOLD FAMILY DENTISTRY