Yahara Dental S.C.
FAMILY • GENERAL • COSMETIC
THOR J. ANDERSON, DDS

Release of Records

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Family members transferring: _____

_____

Name of Dentist: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Fax: _____ Email Address: _____

Date of Appointment: _____

I authorize the release of my dental records and x-rays to be sent to my new dentist.

Signed: _____

Dated: _____

1520 Vernon Street | Stoughton WI, 53589
Ph 608.873.7277 | Fax 608.873.7254 | info@yaharadental.com
www.yaharadental.com