I (we) do hereby authorize Mike Beckham, DDS to release dental x-rays of the person(s) named below to the dentist/physician indicated below.

Complete the information below. If the records are for a minor or if you are a guardian for a patient then the parent or guardian should sign the request. Each patient 18 years and older is required to sign for transfer of their records.

Name **Date of Birth** **Signature**

_____

_____

_____

_____

_____

Send Records to:

Dentist Name:_____

Email (we can email most records):_____

Address:_____

City_____St_____Zip_____

Phone_____ Fax_____

Please return this form to:

Mike Beckham, DDS
4815 E Carefree Hwy, Suite 102
CaveCreek, AZ 85331

Or:

info@beckhamdental.com