RECORDS TRANSFER

TO:_____
DENTIST'S NAME

_____
STREET ADDRESS

_____
CITY, STATE, AND ZIP

_____OFFICE_____FAX
PHONE AND FAX NUMBERS

_____ has authorized transfer of dental records to Dr. Oswald and Siedlecki's office. Please foward any x-rays and periodontal charting you may have on file.

_____
Patient's Signature

From: John C. Oswald D.D.S.
Jodie D. Siedlecki D.D.S., Inc
5885 State Road
Parma Ohio, 44134
Phone 440-886-1916
Fax 440-885-7114