I, _____, hereby authorize
(Patient's Name)

_____
(Former Dental Office Name and Dentist Name)

to provide Kircher Family Dentistry / Dr. Kali B Kircher, DMD with copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes detailed reports of examinations, treatment provided, dental radiographs and all other records which pertain to me.

This consent is effective immediately.

Patients Name: _____
Patient's Date of Birth: _____
Signature: _____
(Parent, legal guardian, or POA of patient, if patient is unable to sign for themselves)

Please send all dental records to:
Kircher Family Dentistry
Dr. Kali B Kircher, DMD
3523 Main Street
Keokuk, Iowa 52632
319-524-1431 (phone)
319-524-5905 (fax)
frontoffice@kircherfamilydentistry.net

Please send all radiographs via mail or e-mail only. Please do not send radiographs via fax.