Dr. William J Twohig DDS
PO Box 579
Weyauwega, WI 54983
Phone: (920)867-3101
Fax: (920)867-3108
Email: info@drtwohig.com

Patient Authorization to Transfer/ Forward Records

I, ____, hereby request and authorize
(*Patient or Guardian name,* ***please print***)

____
(Current *practice or dentist name*)

to turn over my dental records to **Dr. William J. Twohig DDS**.

By authorizing the transfer, I understand that I am not impairing

____
(*Name of current dentist transferring records*)

right of access to my records, when necessary, during the time period in which I was under his/ her care.

Sign: ____
(*Patient or Guardian signature*)

Date: ____

Email is our preferred method of transfer. Please send records to: info@drtwohig.com

-OR-

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