



Request for Transfer of Records

****PLEASE MAIL THIS FORM TO YOUR PREVIOUS DENTIST****

I authorize the release of my dental records and radio-graphs to
Londonderry Family Dentistry.

Patients Name	Patient/Parent Signature	Date
Patients Name	Patient/Parent Signature	Date
Patients Name	Patient/Parent Signature	Date
Patients Name	Patient/Parent Signature	Date

Please transfer records and radiographs for the above patient(s) to.....

**Londonderry Family Dentistry
Dr Jana Trnovsky
356 Mammoth Road
Londonderry, NH 03053
(603) 432-5094
E-Mail – Wendy@Londonderryfamilydentist.com**

Thank you in advance for your cooperation in this matter