Theresa A. Casper-Klock, D. D. S.
33 William Street, Suite 1
Auburn, NY 13021
(315) 253 - 8891

TO: _____

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AUTHORIZATION FOR TRANSFER OF RECORDS

I hereby authorize your office to send copies of any pertinent documents, and diagnostic quality copies of x-rays taken within the last 12 months, to the office of Dr. Theresa Casper-Klock:

This authorization applies to the following individual(s):

_____

_____

_____

_____

_____

(PLEASE PRINT CLEARLY)

_____
SIGNATURE OF PATIENT OR PARENT

_____
DATE