DAVID H. KLEKAMP, D.D.S., P.C.

6000 E. EVANS AVE., BLDG. 1, SUITE 130
DENVER, COLORADO 80222-5406
(303)759-2807 ▲ FAX (303) 759-5853
INFO@KLEKAMPDENTIST.COM

CONSENT FORM
TO OBTAIN DENTAL RECORDS

I hereby consent to the release of a copy of dental records (**radiographs and chart**) for :

_____
(Patient Name)

from the office of _____
(Previous Dentist Name)

to the office of Dr. David H. Klekamp.

Please e-mail or direct mail these to:

David H. Klekamp
6000 E. Evans Ave. 1-130
Denver, CO 80222
info@klekampdentist.com

When e-mailing x-rays the preferred formats are: .dex & .jpg.

Thank you.

_____
Patient's Name (print)

_____
Patient's Signature (or legal guardian)

_____
Date