vh dental

2700 5 Mile Road NE, Suite 100
Grand Rapids, MI 49525

p 616 361-9290
f 616 320-3222
w www.vh-dental.com

Authorization for Release of Dental Records and X-rays

I, (***print patient name***) _____, hereby authorize the doctors and staff of (***Name of dental office or dentist you are transferring care FROM***)_____to release records or knowledge concerning my dental health **to:**

VH Dental

2700 5 Mile Road Ne Suite 100

Grand rapids, MI 49525

Email: office@vh-dental.com

Practice Contact Number: 616-361-9290

Expiration of authorization to transfer records (6 months if left blank):_____

Reason for leaving:_____

Signed (*patient or guardian name*)_____

Printed (*patient or guardian name*)_____

Date _____

Please complete this form and email to office@vh-dental.com, text a photo of the completed form to 616-361-9290, or mail/deliver to:
2700 Five Mile Rd Ste 100
Grand Rapids, MI 49525

Please call or text our office at (616) 361-9290 with any questions ☺