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| To the office of: |  |

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| --- | --- |
| Address: |  |

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| --- | --- | --- | --- | --- | --- |
| Phone: |  | Fax: |  | E-Mail: |  |

|  |  |
| --- | --- |
|  | has requested dental x-rays and records to be transferred to, |

Christopher A. McConnell, DDS

200 W. County Line Road, Suite 240

Highlands Ranch, CO 80129

e-mail:[cmccdds@gmail.com](mailto:cmccdds@gmail.com)

303-791-6900

I authorize transfer of my x-rays and records to Dr. McConnell

|  |  |  |  |
| --- | --- | --- | --- |
| Patient E-Signature: |  | Date: |  |

[cmccdds@gmail.com](mailto:cmccdds@gmail.com) | 303-791-6900 phone | 303-791-7954 fax

Highlands Ranch Health Care Plaza | 200 W. County Line Road, Suite 240 Highlands Ranch, CO 80129

Fellow American College of Dentists |Fellow American Association of Hospital Dentists | Fellow Delta Sigma Delta