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Request for Transfer of Records

I, _____ hereby request and give my permission to Dr. _____ to provide Dr. Knierim any and all information regarding past dental care and x-rays for my child, _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultations, prescriptions, models, and copies of all dental and medical records.

Please have the records sent to:

Erin A. Knierim, D.M.D., M.S.
3036 W. Sylvania Ave.
Toledo, Ohio 43616

Or, they can be e-mailed to drkdental@bex.net. We would prefer x-rays by email because we are paperless and can import the x-rays directly into the patient's chart. Thank you.

Signed: _____ Date: _____
(Parent, Legal Guardian, or Custodial Parent)

Address: _____

Phone: _____