



Patient Record/xray release

I, \_\_\_\_\_ request my records/xrays to be transferred to the below dentist.

Murray Scholls Family Dental

14845 SW Murray Scholls Dr, Ste 113

Beaverton, OR 97007

Email: [info@murrayschollsfamilydental.com](mailto:info@murrayschollsfamilydental.com)

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Patient Signature

Date

**Scott R. Walker, DMD and Associates**