RECEIPT FOR OUTPATIENT TREATMENT/DENTAL RECORDS

For use of this form see AR 40-66; the proponent agency is the Office of The Surgeon General.

NAME OF SPONSOR		NEW UNIT OF ASSIGNMENT AND ADDRESS OF SPONSOR	
SSN OF SPONSOR			
NAME(S) OF OUTPATIENT		TREATMENT PERIOD COVERED BY RECORD *(List dates of first and last entries in appropriate column)*	
		MEDICAL	DENTAL
1			
2			
3			
4			
5			
6			

I acknowledge receipt of above outpatient record(s). I understand that if I lose or misplace said record(s), duplicate(s) cannot be furnished. I will deliver said record(s) to: *(Print name and address of medical facility or doctor)*	The exact destination of said record(s) is unknown at this time. Mail can be forwarded to me at the following address: *(Print complete name and address)*

PRINTED NAME *(If other than patient, state relationship)*	SIGNATURE	DATE

DA FORM 3705, JAN 1980 EDITION OF 1 MAR 71 WILL BE USED UNTIL EXHAUSTED. APD LC v1.02ES