AUTHORIZATION FOR TRANSFER

OF DENTAL RECORDS / INFORMATION

Patient(s) Name(s):		Birthdate(s):
Address:		
City:	State:	Zip code:
Phone number:	Email:	

SEND TO • REQUEST FROM (Circle one)

Dental Practice / Dentist's Name:		
Address:		
City:	State:	Zip code:
Phone number:		
E-mail address:		

PLEASE CANCEL ALL UPCOMING APPOINTMENTS NO YES (Circle one)

Reason for leaving: _____

*Authorization for release / transfer of records:

X Date: _____

*(Signature of parent or guardian required if patient is under the legal age of adulthood.)

*** This authorization will remain in effect until which time as the patient (if of legal age) or the parent / legal guardian request otherwise. ****

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