DENTAL RECORDS RELEASE FORM/TRANSFER

Patient's Name: ________________________ Date of Birth: ______________________

Patient's Name: ________________________ Date of Birth: ______________________

Patient's Name: ________________________ Date of Birth: ______________________

Reason for Transfer: Age____ or Other____ (*please tell us why*)___________________________

DISCLOSE TO: □Self □ Dental Provider

____ PHONE: ___________________________
Name of Health Care Provider / Myself

EMAIL ADDRESS: ____

Please Note: All dental records and x-rays are sent electronically via email. Thank you!

SIGNATURE OF PATIENT / OR PARENT/LEGAL GUARDIAN

Signature: ____ Date: _________________

□ parent* legal guardian