Authorization for Release of Dental Records

Patient Name: ______________________________ Phone #: ______________________

Address: __________________________ City: ____________ State: ______ Zip: _______

Email: ____ Patient #: _____________

Transfer From:

Original Dentist: ______________________________ Clinic: ______________________

Phone #: _____________________________ Fax #: _____________________________

Address: _____________________________ City: ___________ State: ______ Zip: ______

Email: ____

Transfer To:

New Recipient: _______________________________ Clinic: ______________________

Phone #: _____________________________ Fax #: _____________________________

Address: _____________________________ City: ___________ State: ______ Zip: ______

Email: ____

Authorized Information to Disclose:

- o Exam/Treatment Notes
- o X-Rays
- o Treatment Plans
- o Other: _________________

Method of Transfer:

____

Reason for Transfer:

____

I, the patient, understand that I may revoke my consent, in writing, at any time. I understand that my information will be held in the strictest confidence and will be read, shared, and held by no parties other than those who transfer the information and those who receive it.

_______________________________ _______________

Patient Signature Date

_______________________________ _______________

Authorized Dental Representative Date