REQUEST FOR TRANSFER OF RECORDS

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PATIENT INFORMATION	
Name:	DOB:
Phone #:	

REASON:

Please provide me a copy of my or my dependents records for the following reasons:

- ☐ Moving Away
- ☐ Changing Dental Offices
- ☐ 2nd Opinion
- ☐ Copy for Dental Specialist
- ☐ Dissatisfied w Service
- ☐ Copy for Personal Records
- ☐ Other

RECORDS:

I would like the following records released:

- ☐ Recent X-rays
- ☐ Treatment Record
- ☐ Periodontal Evaluation
- ☐ Account Information

LOCATION:

I would like to receive the information by:

- ☐ I or another (specify name) _________________________ will pick up records
- ☐ Mail   Name: _________________________________

  Address: _________________________________

  City/State/ Postal Code:___________________________________
- ☐ Email Address: ____

Consent:

1. I authorize this office to release the above specified information to the above noted people and/or places.
2. I understand that Federal Law allows this office 30 days to provide access to the requested information, or to explain why access is denied.
3. I acknowledge that if the requested information is not maintained in this office, Federal Law permits this office 60 days to provide access to the requested information, or to explain why access is denied.

Signature of Responsible Party: ______________________________ Date: ___________Relation to Patient: ______