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:		
Fax number:		
E-mail address:		

*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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