DENTAL RECORDS RELEASE FORM

Patient Information:

Name: _____ **Date of Birth:**_____

Authorizes: _____

Send to: _____

Phone: _____ **Fax:**_____

Email: _____

When transferring information to another dental office, we only send current x-rays within the last year.

If x-rays are over a year, we would take new images.

By signing, understand that the information released per this authorization, if redisclosed by the recipient,

Is no longer protected.

I consent to transferring my dental records_____ **Date:**_____

If parent/guardian, please specify (print name): _____