Request for Transfer of Records

I, _____, hereby request and

give my permission to Dr. _____ to provide any and all information regarding past dental care for

_____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

_____

_____

_____

Signed: _____Date:_____
(Patient)

Signed: _____Date:_____
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address:_____

Address:_____

Phone: _____