Records Release Request

Patients Name of records to be released: ____

Today's Date: ______________________Needed by Date:__________________________________

I, (print patient or guardian name) ______________________________________, hereby authorize the doctors and staff of (previous dentist name) ____________________________ to release my records or information concerning my dental health to:____
____

Additional Family Member(s): ________________________________
____
____

Reason for your transfer: (example) moving, job changes, new insurance, etc.______________________
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____

(Your input is greatly appreciated and will help us to achieve the high standards we hold for our patient care and service.)

Signature (patient or guardian name) : _____________________________________

Printed name (patient or guardian name): _____________________________________

Thank You!