Authorization for Release of Dental Records

Patient Information

Patient Full Name:

Date of Birth: **Phone:**

Email Address:

1. Records From (Releasing Office)

Practice Name:

2. Send Records To (Receiving Office)

New Doctor / Practice Name:

Office Email Address:

Office Phone / Fax Number:

3. Information to Be Released (Check One)

[ ] chart notes, treatment plans and the last 18 months of digital X-rays

4. Patient Acknowledgement

- I understand that this authorization is entirely voluntary.
- I understand that my records will be transferred digitally via secure, encrypted email.
- I understand that I may revoke this authorization in writing at any time before the files are transmitted.

Patient / Guardian Signature: **Date:**