Patient Authorization to Transfer or Forward Dental Records

I, _____, hereby request and authorize
Patient or Guardian Name (please print)

_____ to turn over my dental records to Dr. _____,
Practice or Dentist Name

or to forward a copy to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be transferred to Dr. _____ on _____*(Date)*_____.

By authorizing this transfer, I understand that I am not impairing Dr. _____ _____ from the right of access to my records, when necessary, during the time period in which I was under _____*(his/her)*_____ care.

_____
Name of new dentist, specialist.

_____
Street Address

_____
City *State* *Zip* *Telephone Number*

Signed:_____ Date:_____
Patient or Guardian