Release of Dental Records

Patient

Name: _____ Patient ID: _____

Phone: _____ Email: _____

Address: _____

Transfer From

Original Dentist: _____ Clinic: _____

Fax: _____ Email: _____

Phone 1: _____ Phone 2: _____

Address: _____

Transfer To

New Recipient: _____ Clinic: _____

Fax: _____ Email: _____

Phone 1: _____ Phone 2: _____

Address: _____

Authorized Information to Disclose

- ☐ Exam/Treatment Notes
- ☐ X-Rays
- ☐ Treatment Plans
- ☐ Other:_____

Method of Transfer

- ☐ FAX
- ☐ Email
- ☐ U.S. Mail

- ☐ Other: _____

Reasons for Disclosure

- ☐ Legal Requirement
- ☐ Insurance Claim or Dispute
- ☐ New Dental Care Provider
- ☐ Specialist Consultation
- ☐ Second Opinion
- ☐ Other:_____

I, the patient, understand that I may revoke my consent, in writing, at any time. I understand that my information will be held in the strictest confidence and will be read, shared, and held by no parties other than those who transfer the information and those who receive it.

(Patient's Signature)

_____

(Dentist's Signature)

_____

(Date)

_____