Dental Records Transfer Request Form

Please complete this form to authorize the transfer of your confidential dental records. Once completed, please print, sign, and submit this form to your current dental provider.

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1. Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Street Address:

City, State, Zip Code:

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2. Current Dental Practice (Releasing Records)

Clinic or Dentist Name:

Phone Number:

Email or Fax:

Mailing Address:

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3. New Dental Practice (Receiving Records)

Clinic or Dentist Name:

Phone Number:

Email or Fax for Records:

Mailing Address:

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4. Records to be Transferred

Specify Records (e.g., All Records, X-rays only, Diagnostic reports):

Reason for Transfer (e.g., Relocation, Second Opinion, Changing Providers):

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5. Authorization and Signature

I hereby authorize my current dental provider listed in Section 2 to release and transfer my dental records to the receiving dental practice listed in Section 3. I understand that this authorization is voluntary and that I may revoke it at any time in writing.

Patient or Guardian Signature: _____

Relationship to Patient (if signed by Guardian): [ ]

Date Signed (MM/DD/YYYY): [ ]