**Request for Transfer of Patient Records**

Please send a copy of the following for me and/or my family members (listed below) to the office specified.

\_\_\_\_ Dental records, including dates of last checkup and dental cleaning

\_\_\_\_ All dental x-rays taken in the past 2 years (5 years for a PAN) including date of imaging

Patient First Name\* Patient Last Name\* Patient Date of Birth\*

(day/month/year)

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Former Office Name Former Office Phone #

|  |  |
| --- | --- |
|  |  |

Former Office Fax# Former office email

|  |  |
| --- | --- |
|  |  |

Consent to transfer:\*

I consent to having these records transferred either electronically or by mail, at the discretion of the transferring office.

Signature of requester Date of request

|  |  |
| --- | --- |
|  |  |

Who is signing to provide consent to this records transfer?

Patient \_\_\_\_\_ Patient’s parent or legal guardian \_\_\_\_\_