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Authorization for Transfer of Dental Records and X-rays

Name of Patient: _____

Patients DOB: _____

Address: _____

City/State/Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, (print patient or authorized representative) _____, hereby authorize the release of my/our dental x-rays (current bitewings, panorex, and full-mouth if available) and other healthcare information to include chart notes, periodontal charting to the office of:

Doctor: _____

Address: _____

City/State/Zip: _____

Will send electronically if requested: Email address: _____

Signature _____ Date _____

(Patient or Authorized Representative signature)