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Request to Release Records-Transfer Out

Patient Name: ____

Date of Birth: _______________________

Parent/Guardian's Name: ____

Phone Number: _____________________

I hereby authorize the release of dental/medical records, including but not limited to personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans and records, referral/consultation recommendations/reports, diagnostic models and any other related materials or copies of such:

Send Records to Doctor: ____

Office Email Address: ____

Phone Number: (_____) ________-_________

Date Records are needed by: _______________________

Parent/Guardian Signature: _______________________________ Date: ________________