Dental Records Release Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Phone number: _____ Email: _____

Address:

CURRENT DENTAL PRACTICE INFORMATION

Name of current dental practice: _____

Address:

Phone number: _____ Email address: _____

NEW DENTAL PRACTICE INFORMATION

Name of current dental practice: _____

Address:

Phone number: _____ Email address: _____

Date of release: _____ dd / mm / yyyy

PATIENT CONSENT AND AUTHORIZATION

I, the undersigned, hereby authorize the transfer of my/patient's dental records from the current dental practice listed above to the new dental practice specified above. This authorization includes, but is not limited to, the release of dental history, treatment reports, X-rays, and laboratory results. I understand that this transfer is essential for ensuring the continuity of dental care and treatment.

Patient/legal guardian's name: _____

Patient/legal guardian's signature

Date: _____ dd / mm / yyyy

WITNESS/HEALTHCARE PROVIDER ATTESTATION

Witness/healthcare provider signature

Date: _____ dd / mm / yyyy