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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)