

## Request for Transfer of Records

I, \_\_\_\_\_, hereby request and give my permission to  
Dr. \_\_\_\_\_ to provide Dr. \_\_\_\_\_  
any and all information regarding past dental care for  
\_\_\_\_\_.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_