Transfer of Patient Records Consent Form

Dental office/Address:

Date:_____

_____

_____

I, _____ , hereby request the following from my dental records…
(Patient's name)

Check the following boxes(s):

☐ Chart Only
☐ Recent Radiographs (last 2 years)
☐ Models
☒ **C**omplete dental records including patient chart, radiographs, models, photographs, and any other documents including referral letters and correspondence with specialists and/or insurance companies

Check one of the following:

☐ Released into my possession
☐ Sent electronically (where possible) to the following email address _____
☐ Forwarded to the following dental office/dentist address:

_____
_____

I understand that only copies of my records and duplicates of my radiographs and models will be provided, and that if no duplicates can be made, that the originals will be forwarded to the address above and returned to the sending dentist.

_____
(Patient's signature)