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AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

FROM PRIOR OFFICE to No Sugar Bugs Club

I authorize transfer of all records, including financial and x-ray information to No Sugar Bugs Club for the above named child(ren).

*Office Name: _____

*Phone #: _____

*Email: _____

Parent/Guardian Name (signature): _____ Date: _____

FROM NO SUGAR BUGS CLUB to New Office

I authorize transfer of all records, including financial and x-ray information from No Sugar Bugs Club to:

*Office Name: _____

*Phone #: _____

*Email: _____

REASON FOR LEAVING: Relocated: _____ 2nd Opinion: _____ Insurance: _____

Other: _____ (please explain) _____

Parent/Guardian Name (signature): _____ Date: _____

*Required information. Please note that all patient records are electronic in nature. We must be able to transfer digital films via email.
***We will respond to you within 5 business days.