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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 Trinity Pediatric Dentistry
I authorize transfer of all records, including financial and x-ray information to Trinity Pediatric Dentistry for the above named child(ren).

*Office Name:_____

*Phone #: _____

*Email:_____

Parent Name (signature) _____ Date: _____

Office Only Received records date: _____ Scanned to NP Correspondence _____ Staff Initials _____

From Trinity Pediatric Dentistry to New Office
I authorize transfer of all records, including financial and x-ray information from Trinity Pediatric Dentistry to:

*Office Name:_____

*Phone #: _____

*Email:_____

Reason for leaving: Relocated: _____ 2nd Opinion: _____ Insurance: _____

Other: _____ (please explain) _____

Parent 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 7 days.

Office Only Doctor Reviewed: _____ Sent Records date: _____ Staff Initials: _____