authorization to release patient records

I authorize Southwest Pediatric Dentistry and Orthodontics, P.C.
to release the records of:

Patient's Name: _____ DOB: _____

Patient's Current Address: _____

Transfer to: (Either new home or new dental office)

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Email: _____

Reason for transfer: _____

We try to do so in an efficient manner, but **please allow 5–7 business days to transfer records.**

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Name Relationship to Patient

Email of responsible party: _____

pediatric dentistry & orthodontics p.c.
southwest
adult dentistry

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