PATIENT RECORDS RELEASE FORM

Date:_____

Patient Name: _____

Date of Birth: _____ Phone number: _____

I authorize [insert name of dental clinic] to transfer my dental records to:

_____

Through the following methods (circle and describe all those that apply):

- Mail provide address (records will be sent within 2 weeks)
  _____
- In-person pick up_____ Please check if yes
- Email_____

Print Name: _____

Signature: _____

*Please allow our office **one week** to get all records ready