17025 N. Scottsdale Rd., Suite 125
Scottsdale, AZ 85255
480-534-7144

Dental Records Release Form

Patient Name: _____

Date of Birth: _____

Phone number: _____ Email: _____

Other Family members to transfer: _____

_____

Name of New Dentist or Office Authorized To Receive Protected Health Information:

_____

Address: _____

Email Address: _____

Phone: _____ Fax: _____

Records authorized for release (circle any that apply):

X-rays
Periodontal Exam Chart
Treatment Plan
Patient Ledger
Clinical Notes

Patient/Guardian signature: _____

Date: _____

Relationship To Patient: _____