Dental Records Release Form

Patient name to transfer : _____

Date of Birth : _____/_____/_____ Phone Number : (_____) _____-_____

Other family members to transfer : _____

Previous Dentist or Practice Name : _____

Address : _____ City, State, and Zip : _____

Phone Number : (_____) _____-_____

Please forward any of the following information that you have which is dated within the last five years: *x-rays, probing depth chart, charting, and photographs*. Please send requested records to the email or physical address listed below. **Email is preferred if records are digital.**

I, _____ hereby give my permission for the dental office listed above
(Printed name of patient or parent if a minor)

to release the specified dental records to the office of Anne M. Breum, D.M.D., P.C. I have read and understand this form. I am signing it voluntarily. I understand this authorization will be effective until revoked by me in writing.

Signature of Patient or Legal Guardian_____

Date Signed_____

**When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

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