Request for Transfer of Records

I,	, hereby request and give my permission to
Dr	to provide Dr
any and all informat	ion regarding past dental care for
Such records may in	clude medical care and treatment, illness or injury, dental
history, medical hist	ory, consultation, prescriptions, radiographs, models and
copies of all dental re	ecords and medical records.
Please have these re-	cords sent to:
Signed:	Date:
	atient)
Signed:	Date:
(Parent, Legal (Date: Guardian or Custodian of the Patient, if Patient is a Minor)
Address:	
Address:	
Phone:	