



## Patient Records Release Form

When a patient moves, or, for other reasons, there is a necessity to change dental clinics during the course of ongoing dental treatments, it is highly advantageous for all parties involved that the transfer be as prompt and convenient as possible.

It is necessary that your records be transferred to assure that the receiving dental clinic is knowledgeable of your current condition(s), treatment objectives, treatment plan, and related financial arrangements. To facilitate the transfer of these records, it is necessary that you complete the following:

I authorize \_\_\_\_\_ to release all records of

[Current Dental Clinic]

\_\_\_\_\_ for the purpose of continuation of treatment by another dental clinic.

[Patient's Full Name]

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

[Patient or Legal Guardian]

**Print Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Additional Notes:**