

# Family Dental Clinic

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## TRANSFER OF DENTAL RECORDS & RADIOGRAPHS

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby authorize the use and disclosure of the patient information. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.

**I will no longer expect the original dental clinic to be responsible for the maintenance of these records.**

Transfer:

Patients current **dental x-rays** (list type of x-rays and date.) and Records.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send to: Name: \_\_\_\_\_

Address: \_\_\_\_\_

e-mail: \_\_\_\_\_

Sent from: \_\_\_\_\_ Family Dental Clinic \_\_\_\_\_ Other: \_\_\_\_\_

1119 Sims

Dickinson ND 58601

Signed: \_\_\_\_\_

Patient, Parent or Legal Guardian if patient is a minor

Date: \_\_\_\_\_