AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS - TRANSFER

**Patient, Parent or Legal Guardian please fill out the information below which will serve as a request and authorization for disclosure of records and information concerning my care which is in possession of the person or entity indicated below:**

|  |
| --- |
| Practice Location:  |
| Patient’s Date of Birth: |
| Patient’s First Name: |
| Patient’s Last Name:  |
| Patient’s Address:  |

**Patient, Parent or Legal Guardian to complete the information below. If no new dentist has been identified the record will be sent to the patient’s address indicated above.**

|  |
| --- |
| Name (new dentist):  |
| Street Address:  |
| City: State: Zip:  |
| Telephone Number:  |
| Email Address:  |

**While your complete dental record is always available to you upon request, our general practice with a patient transfer is to send the most recent x-rays (radiographs), and progress/treatment notes unless additional information is requested. With regard to progress/treatment notes, please indicate below the date range that you are requesting this information for:**

 From \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**I expressly release from liability the above-named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.**

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

**(Patient or Parent/Legal Guardian) Please send this completed form back electronically to: Info@precisiondentalmke.com If you are unable to send this completed/signed form back electronically, please send to: 6203 S Howell Ave. Milwaukee, WI 53207**