REQUEST FOR THE TRANSFER OF DENTAL RECORDS AND X-RAYS

PATIENT INFORMATION:

_____
Full Name

_____
Street Address

_____
City, State, Zip Code

_____/_____/_____ _____
Date Of Birth Phone Number

INFORMATION TO BE DISCLOSED:

☐ Radiographs (X-rays)

☐ Other (Specify):_____

By signing below, I authorize the practice of

NorCal Pediatric Dentistry

1111 Sonoma Avenue
Santa Rosa, CA 95405
T: (707) 544-4611 F: (707) 544-6835

to release records or knowledge concerning my dental health to:

☐ Given directly to me
☐ Sent directly to a dental office

_____
Practice Name

_____
Address City/State/Zip

_____
Telephone Fax

_____
Email

_____
Patient's or Guardian's Signature Date

 Version 1 Effective Date: 08/01/2018

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