Records Release

Patient Name: ______________________________ DOB ________________

Please include the NAMES and BIRTHDATES of any family members you wish to include in this records release:

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TRANSFER RECORDS TO Sunfish Dental. I authorize the following clinic to release my records, including all requested dental information, copies or photocopies of my dental record and radiographs, concerning treatment given to me at:

Dental Practice Name: ____

Phone Number: ____________________ Email: _________________________

Address: ____

Reason for Leaving: Moving
Insurance is out of network
Hours of Operation
Billing Problem
Other (Please specify):______________________________________

TRANSFER RECORDS FROM Sunfish Dental. I am requesting my records be sent to:

[NEW OFFICE] Dentist/Clinic Name: _____________________________

Phone Number: _____________________ Email: _____________________________

Address: ____

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Signature of Patient or Parent/Guardian

_________________________ __________________
Relationship to Patient Date