

# Records Release Form

Patient Transferring: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Other Family Members Transferring:

- 1. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 2. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 3. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 4. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 5. \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Send records to myself:**

Email: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Transferring records out of Eagle River Smiles to a new provider:**

Office name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Office Email: \_\_\_\_\_

Please Send (select one):  X-rays and Records  Xrays Only  Records Only

**Transferring records into Eagle River Smiles:**

My previous dental provider's information:

Office Name: \_\_\_\_\_

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

Fax Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

**Please send digital records to:**

This form expires on: \_\_\_\_\_, 20\_\_\_\_

I hereby grant permission to Eagle River Smiles to release or obtain information related to my dental/medical history, clinical notes and x-rays/photos to the about noted recipient.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_