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 povider's infromation:
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/photots to the about noted rcipient.

Signature of Patient or Guardian:_____Date:_____