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PERMISSION FORM: PATIENT RECORD OR CHART 'TRANSFER VIA MAIL / FAX ' FROM OFFICE

DATE: \_\_\_\_\_

FOR:

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
BIRTH DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
BIRTH DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
BIRTH DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
BIRTH DATE

These Chart(s) Are Taken FROM:  
(Dental Office Name, Address, & Phone)

These Chart(s) Will Be Transferred TO:  
(Dental Office Name, Address, & Phone)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Permission to release Patient Chart Records, X-rays, and other pertinent chart information:

By signing this form, I give my permission for the Office of \_\_\_\_\_

DENTAL OFFICE HOLDING RECORDS

to transfer original or duplicate Patient Chart Records, X-rays, and other pertinent chart information of the patients so designated above, by me, to the specified Dental Office.

\_\_\_\_\_  
PATIENT / GUARDIAN / AUTHORIZED PERSON'S SIGNATURE

\_\_\_\_\_  
DATE