Dental Records Release Form

Patient Transferring: _____

Date of Birth: ____/_____/_____ Telephone Number: (_____) _____

Current Address: _____

□ **Transferring records out of Bonar Family Dentistry, LLC to a new provider:**

New provider's name:

Address: _____

Office e-mail: _____

□ **Transferring records to Bonar Family Dentistry, LLC:**

My previous dental provider's information:

Dentist or Office Name: _____

Address: _____

Email (print clearly*) or phone contact:_____

Please send digital records to: dentist@bonarfamilydentistry.com

I hereby grant permission to **Bonar Family Dentistry, LLC** to release or obtain information related to my dental/medical history, clinical notes and x- rays/photos to the above noted recipient.

_____

Patient Signature (parent if minor) **Date**