Signature FAMILY DENTISTRY
A gentle approach to dental care

Authorization of Transfer Medical Records

Patient Information

Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____

I Authorize for Release. I authorize Signature Family Dentistry of 1755 Parker Road SE, Suite A110 Conyers, Georgia 30094 to release, disclose, and deliver the medical/dental information to the described below. I understand that there is a **fee of $25.00-$65.00** if Dental Records (radiographs) are directly emailed to my personal email address. The records transfer is at no cost to me if sent directly to another dental office. I understand and agree to these terms. **Once your records are transferred to another dental office you will be inactivated in the system to reduce multiple claims submissions.**

Authorized Recipient:

_____

_____

_____

Office Phone: _____ Fax: _____

Office Email Address: _____

I specifically authorize the release of Dental medical records (including dental radiographs) related to the above patient. The release doesn't re-disclosure of dental medical information beyond the limits of this consent. Recipient of this information is prohibited from using the information for other than the stated purpose and from disclosing it to any other party without further authorization.

_____ Date: _____

Patient's Signature

_____

Printed Name of Patient