Transfer of records and release of patient information for ADULT patient

By signing this form, I am granting Dental Care 4 Kids (aka Dr. Gonzales and Dr. Wickersham) my permission to release copies of my radiographs and patient records to other dentists or healthcare providers. I will provide all the necessary contact information below so that the records can be directed to the appropriate party. I am aware that all original radiographs and records will be retained by Dental Care 4 Kids indefinitely.

Patient's Name (s):_____ DOB: __/__/___

Signed: _____ Date: _____

Printed Name:_____

Information for records transfer (per HIPAA rules, must be provided):

Name of office/practitioner: _____

Address:_____

Phone #:_____

Fax #:_____

Email for radiographs:_____