

# Sample Form: Patient Authorization to Transfer or Forward Dental Records

I, \_\_\_\_\_, hereby request and authorize  
*Patient or Guardian Name (please print)*

\_\_\_\_\_ to turn over my dental records to Dr. \_\_\_\_\_,  
*Practice or Dentist Name*

or to forward a copy to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be transferred to Dr. \_\_\_\_\_ on \_\_\_\_\_(Date)\_\_\_\_\_.

By authorizing this transfer, I understand that I am not impairing Dr. \_\_\_\_\_(doctor that is copying or transferring records)\_\_\_\_\_ from the right of access to my records, when necessary, during the time period in which I was under \_\_\_\_\_(his/her)\_\_\_\_\_ care.

\_\_\_\_\_  
*Name of new dentist, specialist, consultant, patient, attorney, insurer, etc.*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip*

\_\_\_\_\_  
*Telephone Number*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient or Guardian*

This sample form is for illustrative purposes only. Your form's content and layout may be different. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice. Published by CNA and provided through the Dentist's Advantage insurance program and the National Society of Dental Practitioners. Copyright © 2019 CNA. All rights reserved. Published 5/19.