# AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS - TRANSFER

Patient, Parent or Legal Guardian please fill out the information below which will serve as a request and authorization for disclosure of records and information concerning my care which is in possession of the person or entity indicated below:

| | |
|---|---|
| Midwest Dental Practice Location: | Patient's Date of Birth: |
| Patient's First Name: | Patient's Last Name: |
| Patient's Address: | |

Patient, Parent or Legal Guardian to complete the information below. If no new dentist has been identified the record will be sent to the patient's address indicated above.

| | | |
|---|---|---|
| Name (new dentist): | | |
| Street Address: | | |
| City: | State: | Zip: |
| Telephone Number: | | |
| Email Address: | | |

While your complete dental record is always available to you upon request, our general practice with a patient transfer is to send the most recent x-rays (radiographs), and progress/treatment notes unless additional information is requested. With regard to progress/treatment notes, please indicate below the date range that you are requesting this information for:

From ____ / ____ / ____ To ____ / ____ / ____

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed: _____ Date: _____

*(Patient or Parent/Legal Guardian)*

Please send this completed form back electronically to: records@midwest-dental.com

If you are unable to send this completed/signed form back electronically, please send to:
Records Department
P.O. Box 69
Mondovi, WI 54755