Magical Smiles
Family Dentistry

Request for Transfer of Records

I, _____, hereby request and give my permission to Dr. _____ to provide any and all information regarding past dental care for _____.

Such records may include dental care or treatment, illness or injury, dental history, medical history, consultations, prescriptions, x-rays, models and copies of all dental records.

Please have records sent to:

Office: _____

Email: _____ Phone: _____

Reason for request/leaving:

_____

_____

_____

_____

Patient Signature: _____ Date _____

Parent/guardian: _____ Date _____

Doctor Signature: _____ Date _____