Theil & Theil
D.D.S.

General Dentistry

DENTAL RECORDS RELEASE FORM

Patient Name to transfer: ____

Date of birth: ________________ Phone number: ________________

Other family members to transfer: ______________________________________

Please forward any of the following information that you have: recent x-rays, probing depth chart and photographs to:

Dentist or Practice Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Phone Number: ____________________

Email Address: ____________________

I hereby give permission to release any and all of my dental records to:

______________________________________ (Dentist or Practice Name)

______________________________ ______________________________

Patient Signature (parent, if a minor) Date

DISCLOSURE:

This message is intended only for the use of the individual(s) to whom it is addressed and contains information that is privileged, confidential, and exempt from disclosure under applicable law. Any further dissemination of copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone or email. This message is provided in accordance with HIPAA Omnibus Rule of 2013.