Hilliard Pediatric Dentistry
5138 Norwich Street
Hilliard OH 43026
Phone: 614-876-5500
Fax: 614-876-8773
Email: office@hilliardpediatricdentistry.com

Authorization to Transfer Dental Records

Date: _____

Provide Name and Email address for where records are to be sent:

_____

_____

_____

Please indicate all family member's that need records transferred.

Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please authorize the release of these records by signing below.

Authorized Signature: _____

- **As a courtesy, we require up to two weeks to process request with no charge. If request is needed sooner than two weeks, there is a $15 fee per child. Thank you!**