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: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

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!

www.hilliardpediatricdentistry.com

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