REQUEST FOR TREATMENT RECORD TRANSFER
AND/OR PROFESSIONAL CONSULTATION

Date: .....

Patient's Name: ----- Chart Number: .....

Date of Birth: ----- Parent/Guardian: .....

I hereby request the following records to be transferred from Dr. ..... to:

Name: ..... Tel: -----

Address: ..... Fax: -----

Records:

- ☐ Radiographs (x-rays)
- ☐ Restorative and surgical treatment completed over the last 5 years
- ☐ Study models, photographs, and diagnostic records from the last 5 years
- ☐ Miscellaneous: -----

Pertaining to the above-named patient, I hereby authorize Dr. -----

to discuss the following with .....

- ☐ All information
- ☐ Specific information in relation to: .....

Parent/Guardian Signature: .....

Parent/Guardian Signature: .....