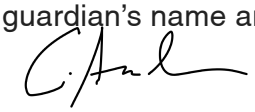
# Dental Release Form

| **Patient Information** | |
|---|---|
| Full Name<br>Carol Anderson | Date of birth<br>March 1, 1991 |
| Address<br>12 Oakwood St, Los Angeles CA | |
| Phone number<br>567-001-1 | Email address<br>carol@email.com |
| **Current Dental Practice Information** | |
| Name of Current Dental Practice<br>Oaktree Dentals | |
| Address<br>30 Oakwood St, Los Angeles CA | |
| Phone number<br>557-991-2 | Email address<br>hello@oaktreedentals.com |
| **New Dental Practice Information** | |
| Name of New Dental Practice<br>Isle of Smile Clinic | |
| Address<br>1 Miriam St, Los Angeles CA | |
| Phone number<br>600-001-2 | Email address<br>hello@isleofsmile.org |
| Date or release<br>January 12, 2024 | |
| I, the undersigned, hereby authorize the release of my dental records from the current dental practice mentioned above to the new dental practice listed above. I understand and agree that this release includes, but is not limited to, the transfer of dental history, treatment reports, X-rays, and lab results.<br><br>I acknowledge that the purpose of this release is to facilitate the continuity of my dental care and treatment. | |
| **Patient Consent and Authorization** | |
| I, the undersigned patient or legal guardian of the patient, understand and consent to the release of my dental records as described above. | |
| Patient/legal guardian's name and signature<br>Carol Anderson  | Date<br>January 12, 2024 |

| **Witness/Healthcare Provider Attestation** | |
|---|---|
| I, the undersigned witness or healthcare provider, verify that the patient or legal guardian has willingly and voluntarily signed this release form and that they appear to understand the implications of authorizing the transfer of their dental records. | |
| Witness/Healthcare Provider Signature<br>  <br>Marc Chua, DDS | Date<br>January 12, 2024 |