

Dental Release Form

Patient Information	
Full Name	Date of birth
Address	
Phone number	Email address
Current Dental Practice Information	
Name of Current Dental Practice	
Address	
Phone number	Email address
New Dental Practice Information	
Name of New Dental Practice	
Address	
Phone number	Email address
Date of release	
<p>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.</p> <p>I acknowledge that the purpose of this release is to facilitate the continuity of my dental care and treatment.</p>	
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	Date

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

Date