RECORD TRANSFER REQUEST

Patient Name: _____
Last name First Middle

Patient D.O.B. _____

I hereby request and authorize, name: _____
(Previous Dentist name)

To release a copy of the following patient records:

{ } X-rays { } Perio Charting { } Photographs { } Full dental records

To: North End Dental P.L.L.C.
704 North 17th Street
Boise, ID 83702
208 344-0134
Fax 208 388-3990
e-mail northenddental@qwestoffice.net

I acknowledge that data to be released MAY INCLUDE material that is protected by Federal laws and that is applicable to ANY and ALL of the above.

My signature below authorizes release of all such information.

Signature of Patient or Responsible Party Date

I, the above signed, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than ninety (90) days from the date signed, unless otherwise stated herein.

To the party receiving this information: This information has been disclosed to you from the records, whose confidentiality is protected by Federal and/or State regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PLEASE FORWARD TO YOUR PREVIOUS DENTAL OFFICE PRIOR TO YOUR APPOINTMENT AT NORTH END DENTAL