



## Atlantic Dental Associates

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### **Dental Records Release Form & Acknowledgement**

#### **Patient Information**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

#### **Office Information**

Location Name & Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

#### **Please select reason for Records Request**

I am permanently relocating to another office. I understand this will immediately end my Patient/Doctor Relationship with Atlantic Dental Associates.

I am temporarily seeing another Doctor (i.e. consult/2<sup>nd</sup> opinion) but will continue to have my routine regular care with Atlantic Dental Associates.

I am a seasonal resident who has another Dental office and would like to have my records regularly shared with this additional office.

Other, please explain: \_\_\_\_\_

Dental Radiographs (xrays) will be sent electronically via secure encryption email.

**Authorization:** I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_