PEGGY BOWN DENTISTRY

Transfer of Patient Records Consent Form

Date: _____

I, _____, hereby authorize_____ office to release my dental records to Peggy Bown Dentistry.

Check the following box(es):

- ☐ Chart Only
- ☐ Recent Radiographs (last 2 years)
- ☐ Models
- ☐ Complete dental records including patient chart, radiographs, models, photographs, and any other documents including referral letters and correspondence with specialists and/or insurance companies.

Check one of the following actions:

- ☐ Send to Peggy Bown Dentistry, mailing information below.
- ☐ Send electronically (where possible) to the following email address: **bowndentistry@gmail.com**

I understand that only copies of my records and duplicates of my radiographs and models will be provided, and that if no duplicates can be made, that the originals will be forwarded to the address above and returned to the sending dentist. I agree to pay any fees related to the copying and transfer of my records, including the duplication of radiographs and models, if necessary.

_____

(Patient Signature)