CNA Sample Form: Patient Authorization to Transfer or Forward Dental Records

I, _____, hereby request and authorize
Patient or Guardian Name (please print)

_____ to turn over my dental records to Dr. _____,
Practice or Dentist Name

or to forward a copy to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be transferred to Dr. _____ on _____*(Date)*_____.

By authorizing this transfer, I understand that I am not impairing Dr. _____*(doctor that is copying or transferring records)*_____ right of access to my records, when necessary, during the time period in which I was under _____*(his/her)*_____ care.

_____
Name of new dentist, specialist, consultant, patient, attorney, insurer, etc.

_____
Street Address

_____
City *State* *Zip* *Telephone Number*

Signed:_____ Date:_____
Patient or Guardian

This sample form is for illustrative purposes only. Your form's content and layout may be different. We encourage you to modify this form to suit your individual practice and patient needs. As each practice presents unique situations and statutes may vary by state, we recommend that you consult with your attorney prior to use of this or similar forms in your practice.