Use this form to transfer records from your office to another provider's.

Dental Records Transfer
From
Myers Pediatric Dentistry & Orthodontics

Date: _____

Name of Patient(s): _____ID/Chart#_____

Address: _____

City: _____State: _____ Zip: _____

Please Circle by which form: Mail/Email/Pick Up:

Email Address:_____

Please transfer the above named patient record(s) to:

_____

From ____/___/____To ____/___/____

Legal Representative's Name (if applicable) _____
Relationship to Individual: _____

Signature of Individual or Legal Representative: _____

- You have a right to have an answer to your request within 30 calendar days.
- If the information is not at this location, you have a right to have an answer to your request within 60 days.
- If there are delays in getting you the answer, you will be told of the delay.
- The delay cannot be more than an additional 30 calendar days
- You may be charged a fee.
- Your request may be denied in certain limited circumstances.

I understand that the term" dental records" includes, but is not limited to, any and all reports, notes, doctor's and/or his employees' notes, clinical; records, x-rays, charts, laboratory reports, test results, histories, diagnosis, opinions information obtained from other health care providers, and administrative information. I further understand obtained from other health care providers, and administrative information. I further understand that Myers Pediatric Dentistry have no control over the release or distribution of requested dental records by those persons or entities to whom I have authorized copies of my records to be released.

I would like the following records to be transferred and/or copied:

*X-Rays _____
*Chart Notes _____
*Ledger Information_____
Staff Member Initials _____