Request to Transfer and/or Receive Patient Records

Patient's Name(s) (print):____

Date of Birth(s): ____

I hereby authorize____**(Dentist Office)**

Office location and fax: ____ **to**

send the following records ____

____

to (circle one) ***Nordstrom Family Dental or Wee Care Pediatric Dentistry.***

Dental Office: ***Please send digital copies of radiographs to***

nordstromdental@mtaonline.net or kellymaixner@gmail.com

Signature: ____**Date:** __________
*Patient or Personal representative***

***Print Name:* ____________________________________*Relationship:* ____________
I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Other Options for this form (disregard for transfer of records):

____ I wish to see the requested records.
____ I wish to receive a paper copy of the requested records.
____ I want you to send the copy of the requested records to:

Name: ____________________________________ Fax: __________________________

Address: ____

____ **I wish to receive an electronic copy of the requested records.**

(PLEASE PRINT VERY CLEARLY!): ______________________@________________________
NOTE THAT WE MUST HAVE A SIGNED COPY OF AN AGREEMENT TO RECEIVE ELECTRONIC INFORMATION ON FILE. We do not send patient information in an unencrypted email because third parties may be able to access the email and it is in violation of HIPAA Security Rule.

____*Date:* _________
Signature of Personal Representative

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