



# NATICK DENTAL PARTNERS

Drs. Kane, Soporowski & Mahdavi

## DENTAL RECORDS RELEASE FORM

Please email completed form to [records@gotfloss.com](mailto:records@gotfloss.com)

Date of Request: \_\_\_\_\_

Transfer of Records                       2<sup>nd</sup> Opinion                       Other \_\_\_\_\_

Reason for Transfer: \_\_\_\_\_

**I authorize NDP to release records to:**

Dentist/Practice Name \_\_\_\_\_ Phone \_\_\_\_\_

Address including city & zip code \_\_\_\_\_

Email \_\_\_\_\_

**Type of records to be released:**

Dental records & x-rays                       X-rays only                       Orthodontic records & x-rays

**Patient Name:**

1. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

3. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

4. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

5. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature (patient over 18, parent or legal guardian): \_\_\_\_\_

Please Print Name: \_\_\_\_\_

*By signing above, I am authorizing Natick Dental Partners to release any records of the individuals listed above including any radiographs that my family or I may have at this office.*

\*\*\* Office Use Only\*\*\*

Balance owed \_\_\_\_\_ Date completed \_\_\_\_\_ Initials \_\_\_\_\_