CORNELL
FAMILY DENTAL

Records Transfer Request

Authorization to Release Dental Records:

Patient Name: _____

Date of Birth: _____

Please send my records to:

Provider Name: _____

Street Address: _____

Phone Number: _____

Email Address: _____

Reason for leaving:

__ Moving

__ Second Opinion

__ Insurance reasons

__ Other; Please explain: _____

I do hereby give permission to Cornell Family Dental to copy my dental records and send them to the provider listed above.

_____ _____

(Signature of patient *or* parent/guardian) (Date)