PARADIGM
Dental Center

Request for Transfer of Records

I, _____, hereby request and give my permission to **Dr. Christina Rosenthal** and/or **Paradigm Dental Center LLC** to provide Dr._____ and/or _____ (practice's name) any and all information regarding past dental care for _____ (patient's name). Such records may include care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records. **Please have these records sent to the following address.** (**PATIENTS:** Write your information if the records will be given to you. Otherwise, write the doctor/practice name below.)

Name:_____

Street Address:_____

City:_____ State:_____

Zip:_____

Dr./Office Phone (if applicable):_____

Dr./Office Email (if applicable):_____

Signed: _____ Date: _____
Patient

Signed: _____ Date: _____
Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

Patient's Address: _____

City:_____ State:_____ Zip:_____

Phone: _____

IMPORTANT: Requests can only be made via email at **paradigmappts@gmail.com**. A separate form must be completed for each family member.

FOR OFFICE USE ONLY

Is this the patient's first request? Yes No
Date of Request: _____ Team Member Initials:_____
Date Mailed/Given: _____ Team Member Initials:_____
Was a copy placed in SmartDoc? Yes No Team Member Initials:_____