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

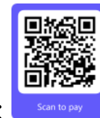
Signed: ____ Date: __________________________
Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)

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. Electronic records mailed are $20 per record. Any mailed records are $25. Payment can be made using the following QR code or link. Once the fee is paid, the record(s) will be distributed using the information on the release form.

LINK TO PAY: https://buy.stripe.com/7sIbJO0y2az40akcMO QR CODE: 

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:___________