Transfer of Records Release Form

Date: ____________

Office Name:____

Phone:_________________________ Email:_____________________________

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they are transferred from:

DAKOTA RIDGE DENTAL

13402 W. Coal Mine Ave. #270

Littleton, CO 80127

Phone: 303-933-2420

Fax: 303-484-3662

Email: info@dakotaridgedental.com

__________________________ Patient Name

____________________________ Date of Birth

_________________________ Patient/Guardian Signature

_____________________________ Relationship to Patient