AUTHORIZATION TO TRANSFER DENTAL RECORDS

Date: _____

DENTIST'S ADDRESS

Dear Dr. _____

RE: _____
Patient's Name

The above-mentioned patient is now attending this practice. Would you kindly forward their clinical records with relevant radiographs, models, photographs, and any other documents including referral letters and correspondence with specialists and / or insurance to assist in the future management of this patient. These records can be forwarded to the following address:

UPTOWN DENTAL

DR. SACHAR DVORKIN B.Sc. D.D.S.
837 Prospect Street
Fredericton, New Brunswick, E3B 5Y4
P: (506) 458 – 9186 F: (506) 450 – 9705
reception@drdvorkin.ca www.drdvorkin.ca

I, _____ (*Patient's Full Name*) understand that only copies of my records and duplicates of my radiographs and models will be provided, and that if no duplicates can be made, the originals will be forwarded to the address above and returned to sending dentist. I agree to pay any fees related to the copying and transfer of my records, including duplication of radiographs and models, if necessary.

_____ _____
Patient / Guardian Signature Date

NOTE

The release and / or transfer of copies of patient records and / or radiographs is a legal and professional responsibility. Such transfer must be done in a timely manner. It is the New Brunswick Dental Society's view that in fulfilling this legal and professional obligations to forward records and / or reports that have been requested by patient, their agent or guardian, a fee may be charged consistent with the direct costs incurred in doing so. An administration fee for this service is not applicable.