2960 Lewis Street NW | Kennesaw | GA 30144
770-422-1554 | bhesterdmd.com

Records Transfer Information/Release

By signing this form, I authorize you to release confidential health information about the patient named below, by releasing a copy of the dental records to the person(s) or entity listed below.

Patient Name: ______________________________

DOB: ______________________________

Limitations on the information you may release are as follows:

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Release the protected Health Information to the following person(s)/entity:

Name: ______________________________

Street: ______________________________

City/State/Zip: ______________________________

-OR-

Email: ______________________________

The reasons or purposes for this release of information are as follows:

____

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______________________________ ______________________________

Patient Name: (Please Print) Patient Signature (Guardian if under 18)

Date: ______________