

Norwich Family Dental Associates

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REQUEST FOR TRANSFER OF COPY OF DENTAL RECORDS

Requesting records from: Doctor: *Please check one:*

R. SNAYD T. FISCHER M. AMARO M. DUNNE

Norwich Family Dental Associates
17 Lafayette Street
Norwich, CT 06360

You are hereby requested and authorized to release all Protected Health Information in the form(s) of Records, Radiographs, and Treatment notes or other information concerning the patient(s) listed below:

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Patient/guardian please fill out:

Reason for Transfer of Records: *optional:* _____

Please forward records to: Name _____

Address ** _____

Phone _____ FAX _____

Email Address: _____

***INCOMPLETE INFORMATION MAY RESULT IN THE DELAY OF THE RECEIPT OF YOUR RECORDS.*

DATE: _____ Patient/Legal guardian _____

(Signature)

1/6/2011 11:32 AM

Approved _____