TRANSFER OF RECORDS RELEASE FORM

Patient Name to Transfer: _____

Phone number: _____ Date of Birth: _____

Other Family Members to Transfer:

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Previous Dentist or Transferring Practice Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

e-mail address: _____

I hereby give permission to release any and all of my dental records. Please forward

all x-rays, charts and dental records to: _____

Records needed from Simply Kids Dental will be available to be picked up within **3 business days** during regular business hours.

Simply Kids Dental
1910 Vindicator Dr St 103
Colorado Springs, CO 80919
Ph: 719-598-5437
Fax: 719-598-9300

Printed Name of Parent/Guardian: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____