Dental Record Transfer Request

To: Dr. Brian L. Kirkwood, Brandywine Dental Group

Re: Transfer Copy of Dental Records for:

_____
(Printed Name of Patient)

The undersigned hereby authorizes and requests that Dr. Brian L. Kirkwood, D.D.S, Brandywine Dental Group, provide a copy of the dental records of the above referenced patient to:

Name of New Dental Care Provider:
_____

Address
_____

Address
_____

Phone
_____

I understand that the medical records to be released may contain confidential medical information, and I hereby authorize the release of this information.

Signed: _____
_____
(Patient or Person in Interest) (Relationship if not Patient)

Date: _____

Return this completed & signed form to:

Brian Kirkwood, D.D.S.
Brandywine Dental Group
101 North State Street
Greenfield, IN 46140