DENTAL ASSOCIATES WEST, P.C.

5310 Pearl Drive, Suite C, Evansville, IN 47712
Phone: (812) 422-1135 / Fax: (812) 422-1978
www.ablogdental.com

RECORDS TRANSFER REQUEST

NEW DENTIST INFORMATION:

DENTIST and/or DENTAL OFFICE NAME: _____

PHONE: _____

ADDRESS: _____

EMAIL ADDRESS: _____

NOTICE

The only records that can be requested for **legal** transfer are that of the person filling out this form and any dependents or individuals of which they are legally responsible for such as children (under the age of 18 and of which they have legal custody), guardianship and in cases of 'power of attorney' (of which our office will require a copy of this legal status). An individual **cannot** request records for another person eighteen (18) years old or older, which includes but is not limited to – spouses, partners, college age children, other family members (siblings, parents, grandchildren, and grandparents), employees, friends, etc.

All records request may be done in person, by fax or by mail. Dental Associates West, P.C. will process all request for patients either in-person (only to authorized patient and/or guardian), via mail or personal delivery to the transferring doctor's office or via secure email (when available to do so).

Below are the individual(s) of which I am requesting records to be transferred to the above listed Doctor's office.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

CURRENT ADDRESS: _____

PHONE #: _____ EMAIL: _____

NAME (print): _____
Patient or Legal Guardian / Responsible Party

SIGNATURE: _____ DATE: _____
Patient or Legal Guardian / Responsible Party