

## REQUEST TO TRANSFER DENTAL RECORDS

I \_\_\_\_\_ hereby authorize  
King Tooth to release and/or transfer the following records:

- Radiographs (PA/BW/FMX/Panoramic)
- Dental Material Biocompatibility Testing
- Chart Notes
- Treatment Records

I request the records to be transferred to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

K I N G T O O T H

- Please allow 5-7 business days to complete all transfer requests.
- If transfer requires scanning or duplicating paper charts, a \$25 fee will be assessed.