THE TOOTH SHOP ON 46, LLC
25520 STATE ROAD 46 • SORRENTO, FL 32776 • 352-735-2211
WWW.TOOTHSHOPDENTISTRY.COM

DENTAL RECORDS RELEASE FORM

Patient Name to transfer_____

Date of Birth _____SS#_____

Address_____

City _____State _____Zip_____

Phone number _____ Email address_____

☐ Patient picked up records in person.

☐ Please forward any of the following information that you have:

_____ X-rays _____ Treatment Plan _____Other:

_____ Periodontal chart _____ Photographs _____

_____ Charting _____ CT Scan

I hereby give you permission to release any and all of my dental records to ☐ THE TOOTH SHOP ON 46 or to:

New Dentist's Name _____

Address_____

City _____State _____Zip_____

Phone number _____ Email address_____

I agree that The Tooth Shop on 46, LLC may send my "Protected Health Information" listed above electronically at the email address above. I am aware that there is some level of risk that third parties might be able to read unencrypted emails and/or open attachments.

I acknowledge that I have received a copy of this dental practice's **"Notice of Privacy Practices"**.

I have general authority to perform all acts on my own behalf and I am responsible for my own decisions. No other person or persons holds a Medical Power of Attorney on my behalf.

Patient (print):_____Signature:_____Date:_____

Privacy Officer:_____Signature:_____Date:_____

Dentist (owner):__Niles A. Syska, DDS____Signature:_____Date:_____

Records Gathered and Information Released by Staff Member_____Date_____

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