MIDTOWN DENTAL

449 Westmorland Street, Fredericton, NB E3B 3M6 ph (506) 458-5606 fax (506) 459-0790

TRANSFER OF PATIENT RECORDS CONSENT FORM

Date: _____

I, _____, hereby request the following from my dental records…
(Patient's Name)

☐ Complete dental records including patient chart, radiographs, models, photographs, and any other documents including referral letters and correspondence with specialists and/or insurance companies

------ OR -----

Define which items below if you have not chosen your complete records to be transferred above:

☐ Chart

☐ Recent radiographs (last 2 years)

☐ Models

Check one of the following:

☐ Released into my possession

☐ Sent electronically (where possible) to the following email address:
admin@midtownfredericton.ca

☐ Forwarded to the following dental office/dentist address:
Midtown Dental, 449 Westmorland Street, Fredericton, NB E3B 3M6

I understand that only copies of my records and duplicates of my radiographs and models will be provided, and that if no duplicates can be made, that the originals will be forwarded to the address above and returned to the sending dentist. I agree to pay any fees related to the copying and transfer of my records, including the duplication of radiographs and models, if necessary.

_____
(Patient's Signature)