Eastern Virginia Pediatric Dentistry, PLC

1806 Hampton Blvd, Suite A
Norfolk, VA 23517
(757)627-7550

Patient Transfer Release Form

I authorize the office of Eastern Virginia Pediatric Dentistry to release copies of dental records for the following patient(s):

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Please send my records to (CHECK ONE):

□ Email Address: _____

□ New Dentist's Mailing Address (ONLY IF THEY CAN NOT ACCEPT EMAILS):

_____

_____

_____

Note: Please allow at least 24 hours for records to be prepared. Thank you.

_____ _____/_____/_____

Signature of Parent/Guardian (MM) (DD) (YYYY)