Dental Records Release Form

Patient Transferring: _____

Date of Birth: _____/_____/_____ Telephone Number: (_____) _____

Current Address: _____

_____

☐ **Transferring records out of Dr. Bobbitt's office to a new provider:**

New provider's name: _____

Address: _____

Office email : _____

- ☐ I prefer to pick up my duplicated dental records. (Please allow 1 week for duplication)
  - ☐ Please attach $15 to cover the cost of duplicating your records/history/x-rays. Check # _____
  - ☐ Credit card payment info:

_____
Print name as it appears on card Card Number

_____
Expiration Date (CVV) 3 digits /back of card Signature

☐ **Transferring records into Dr. Bobbitt's office:**

My previous dental provider's information:

Dentist or Office Name: _____

Address: _____

Email (print clearly*) or phone contact:_____

Please send digital records to: Admin@DrBobbitt.com
We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email. Encrypted email is not currently available so please plan the time necessary for mailing records accordingly.

I hereby grant permission to **SCOTT F. BOBBITT, DMD, PROFESSIONAL ASSOCIATION**, to release or obtain information related to my dental/medical history, clinical notes and x-rays/photos to the above noted recipient.

_____
Patient Signature (parent if minor) **Date**

According to NH State Law, your original records are property of this office and will remain in safe keeping for seven years.