

# Smiley Doctor

**Dr. Reena Gupta DDS**

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## Records Transfer Authorization Form to Dr. Reena Gupta's Office

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

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Dear Doctor or the Office Manager:

Please forward the following records for the above named patient(s) to our office.

\_\_\_Dental radiographs including the most recent full mouth survey or panoramic survey

\_\_\_Copies of treatment records including periodontal chartings and full treatment history

Notes: \_\_\_\_\_  
\_\_\_\_\_

Patient Authorization for release of information:

I authorize the release of my dental records to the office of Dr Reena Gupta, DDS

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

Please release the records for all family members

If the above box is checked, please write the names of all family member and have each member (except minors) sign this form below

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date \_\_\_\_\_

*Dr. Gupta and the staff thanks you for your cooperation in this matter.*