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:____

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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.