Overlake Family Dental
2020 116th NE Suite 220
Bellevue, WA 98004
P:425.453.9999 – F:425.453..7728

Request for Release of Records

I, (Patient/Authorized) _____, hereby request and give my permission to Dr. _____ (previous dentist) to provide

Dr. _____ (new dentist)

_____ (street address)

_____ (city, state, zip)

any and all information he/she requests with respect to the dental treatment of _____ (patient's full name).

------- A photocopy of this release will be considered as effective and valid as original -------

_____ _____

Patient/Guardian Signature Date

We would greatly appreciate your input to help in future care of our patients by letting us know your reason for transferring:

- ☐ Location: _____
- ☐ Problems with our office. Please explain: _____
- ☐ Insurance: _____
- ☐ Moving: _____
- ☐ Other: _____