Records Transfer Form

Patient Name: _____ DOB: _____

Patient Address:

_____

_____

Phone Number: _____

(Check one box) ☐ **Transferring To** ☐ **Transferring From** **Evergreen Dental, PLLC** 7890 Mitchell Road Eden Prairie, MN 55344 Phone: (952) 937-7677 Fax: (952) 937-0232 E-mail: smile@evergreendentalmn.com	(Check one box) ☐ **Transferring To** I hereby request and authorize my records to be sent to the office of Evergreen Dental, PLLC. ☐ **Transferring From** I hereby request and authorize Evergreen Dental, PLLC to disclose and provide copies of any and all clinical records and information concerning my care.
Name of Previous Practice: _____ Address: _____ _____ Phone: _____ E-mail: _____	

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release Evergreen Dental, PLLC from any and all liability arising from compliance with this request and disclosure of the requested information.

Patient Signature: _____ Date: _____