Use this form to transfer records from your office to another provider's.

Records Transfer Request
4Excellence in Dentistry

Date: _____ Practice: _____

Name of Individual: _____ ID#_____

Address: _____

City: _____ State: _____ Zip: _____

Records Transfer Request:

Please transfer the above named patient record to:

Practice Name:

_____

Address:

_____

From ____/___/____ To ____/___/____

Legal Representative's Name (if applicable): _____

Relationship to Individual: _____

Signature of Individual or Legal Representative: _____

- You have a right to have an answer to your request within 30 calendar days.
- If the information is not at this location, you have a right to have an answer to your request within 60 days.
- If there are delays in getting you the answer, you will be told of the delay.
- The delay cannot be more than an additional 30 calendar days.
- You will receive an answer in writing.
- You may be charged a fee.
- Your request may be denied in certain limited circumstances.

For practice use only:
Approved on Date: _____Denied on Date: _____
Delayed Date: _____Will Respond by Date: _____
Comments: _____
Signature Privacy Officer: _____