SEABLUE DENTAL

23914 100th Ave SE, Kent WA
(253) 336-3000 (253) 336-3050
info@seabluedental.com
www.seabluedental.com

Patient's Dental Records Transfer Request

Date: _____

(**The execution of this form does not authorize the release of information other than the terms specifically described below.)

_____

Patient Name | Date of Birth | SSN

_____

Dr. / Office Name | Phone # | Fax# or Email

I request and authorize the above-named doctor or health care provider to release the information requested to the dental office named below on this request.

INFORMATION REQUESTED: ☐ X-rays & Pano ☐ Treatment rendered ☐ Dental chart & TP

☐ Other_____

PURPOSE OF REQUEST: ☐ Transfer of Records ☐Second Opinion

☐ Other, please explain_____

TRANSFER REQUESTED INFORMATION TO:

SEABLUE DENTAL
23914 100TH AVE SE
KENT WA 98031

Tel: (253) 336-3000
Fax: (253) 336-3050
Email: info@seabluedental.com

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____

Name of the Patient | Signature (Patient or Legal Guardian) | Date

(Authorization must be provided by patient of legal age or by legal guardian)