Patient Authorization to Transfer Dental Records

I, _____,

hereby request and authorize William R McGonigle DDS PA to forward a copy of my dental records to my new dentist, whom I have indicated below. I understand that, in the absence of an alternative designation, my records will be retained for 7 years by Dr.McGonigle

By authorizing this transfer, I understand that I am not impairing Dr.McGonigle the right of access to my records, when necessary, during the time period in which I was under *his* care.

Name of new dentist: _____

Address: _____

Telephone number: _____

_____ _____

Signed (*Patient or Guardian)* Date