DAVID J. WEINER, D.M.D., P.A.

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TRANSFER OF RECORDS REQUEST FORM

CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFODRMATION

To: _____

_____

_____

PATIENT INFORMATION:
Name:_____

Address:_____

City, State, Zip:_____

Last four digits of SSN#: XXX-XX-_____

You are hereby authorized to send a copy of dental records as indicated below, to David J. Weiner, D.M.D. You are specifically authorized to disclose verbally, by mail, fax, or encrypted email, any information (including medical information) related to past treatment as David J. Weiner, D.M.D. may require.

Copies of recent radiographs. Full mouth series/panoramic within three years, bitewing radiographs within one year.
Please email if possible JPEG (DEXIS format preferred)
info@bayfrontdental.com

Patient (or patient's representative or guardian)

_____ _____
Signature Date