Scott F. Bobbitt, DMD, MAGD

DENTAL RECORDS RELEASE FORM

Patient Transferring: _____

Date of Birth: _____/_____/_____ Telephone Number (____) _____

Current Address: _____

_____

☐ **Transferring records into Dr. Bobbitt's office:**

My previous Dentist or Office Name: _____

Address: _____

Email (print clearly) or Phone Contact: _____

Please send digital records to: Admin@DrBobbitt.com

Encrypted email used in this office is BrightSquid. We do not recommend sending patient information in an unencrypted email as third parties may be able to access this email.

Office Contact: 76 Allds Street, Suite, 6, Nashua, NH 03060-4758 Phone: 603-882-3001 Fax: 603-882-3683 www.DrBobbitt.com

☐ **Transferring records out of Dr. Bobbitt's office:**

New Provider's Name: _____

Address: _____

Office Email or phone contact: _____

While your complete dental record is always available to you upon request, our general practice with a patient request is to send the most recent x-rays (radiographs) as well as perio charting when available and clinical notes unless additional information is requested. **Physical or CD copies of records may incur a fee*. According to NH State Law, your original records are property of this office and will remain in safekeeping for seven years.

I hereby grant permission to SCOTT F. BOBBITT, DMD, PROFESSIONAL ASSOCIATION, to release or obtain information related to my dental/medical history, clinical notes, and x-rays/photos to the above noted recipient.

X

Patient Signature (parent if minor) Date

Additional MINOR*(S) children to be transferred list below: (*under 18 years of age)

_____

Reason for Release: ___ Moving ___ Insurance ___ Changing Dentist ___ Other: _____