ORANGE CITY
DENTISTRY

TRANSFER OF CARE

Today's Date: ______________________

Dear ____________________________________,

We would appreciate your help in acquiring the following patient's current pantomograph and bitewing radiographs.

PATIENT NAME: ____ DATE OF BIRTH: __________

While our office would prefer digital images, we can receive them by whatever mode is most suitable to your office:

Email: office@ocdentistry.net

Fax: 712-737-8718

Address: 909 Lincoln Circle SE Orange City, IA 51041

NOTES:

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PATIENT RELEASE

I confirm that I am the individual listed below and have the legal authority to initiate a transfer of records containing protected health information for the individual listed above. I authorize the aforementioned provider to release the requested protected health information and send it to Orange City Dentistry in a manner consistent with the Health Insurance Portability & Accountability Act of 2006.

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Signature **Date**

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Printed Name

☐ **Self** ☐ **Parent/Guardian** ☐ **Power of Attorney**