PARK CEDAR
DENTISTRY

Dental Records Transfer/Consent Form

I wish to have the records for:
Name: ____
Date of Birth: ____________________,

Transferred to the office of Park Cedar Dentistry.

Please email them to: info@parkcedardentistry.com
Or
Please forward them to:
10027 Park Cedar Drive (Suite 100)
Charlotte NC 28210

By completing and signing this form I have consented to the release of all information contained in my dental history to the aforementioned dentist.

____ ______________
Patient Signature (If patient is a minor, signature of legal guardian) Date

This request is in accordance with Hippa Guidelines.

Previous Dentist: ____
Previous Dentist Phone Number: ________________________________
Fax Number: ________________________________

Additional Notes: ____
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