**Hospital for Special Care**
**Outpatient Dental Clinic**
**2150 Corbin Avenue**
**New Britain, CT 06053**

# REQUEST FOR TRANSFER OF DENTAL RECORDS

Patient Name: _____ Date of Birth: ____/____/_____

Name and Relationship of Person Making the Request: Phone Number:

_____ (  )_____

_____

This is my request to Hospital for Special Care that a copy of the patient's dental records be provided to me or to the dentist/office listed below for purposes of obtaining dental treatment.

**PLEASE SEND A COPY OF THE RECORDS TO:**

- ☐ PATIENT OR PATIENT'S CONSERVATOR/GUARDIAN/REPRESENTATIVE AT THE FOLLOWING ADDRESS:

  NAME:_____

  ADDRESS:_____

- ☐ DENTIST/DENTAL PRACTICE LISTED BELOW:

  NAME OF DENTAL PROVIDER: _____

  ADDRESS:_____

  _____

Special Confidentiality for HIV/AIDS, Psychiatric and Alcohol/Drug Abuse Records:
I understand that federal and state law provides special protection for records containing information related to HIV/AIDS, psychiatric treatment or alcohol/drug abuse. If my records contain this type of information, this form is also my written permission to disclose such confidential information.

_____ __/____/_____
Signature of Patient (if over 18) or Parent/Guardian/Personal Representative Date

If someone other than the patient is making this request, please indicate below that person's relationship to the patient:

☐ Parent ☐ Guardian ☐ Personal Representative ☐ Conservator

☐ Other: _____