

Special Care Dental Services
411 Osgood Avenue
New Britain, CT 06053

REQUEST FOR TRANSFER OF DENTAL RECORDS

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

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

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This is my request to Special Care Dental Services 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 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 Parent/Guardian/Personal Representative is making the request, describe the person's relationship to the patient:
