CENTRAL MINNESOTA PEDIATRIC DENTISTS, P.A.

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Practice Limited to Pediatric Dentistry, Adolescent and Handicapped

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Date: ______________

I authorize the release of records relevant to dental treatment, or copies of such and request that they be transferred to the following office:

Dental Office: ______________________________

Address: ______________________________

City, State, Zip ______________________________

Email: ______________________________

______________________________ ______________________________

Print Name(s) of Patient **and date of birth** — Signature of Parent/Guardian

Reason for transfer:

- ☐ Graduated from Pediatric Dentist (Due to age)
- ☐ Going to family or general dentist
- ☐ Travel distance
- ☐ Moved
- ☐ Not happy with care provided
- ☐ Other: ______________________________