CENTRAL MINNESOTA PEDIATRIC DENTISTS, P.A.

Practice Limited to Infants and Children

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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: _____

Office Email: _____

Print name(s) of patient(s):

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____
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: _____