



**Kids Dental Experts®**  
**Dental Specialists for Children & Teenagers**  
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## REQUEST FOR TRANSFER OF DENTAL RECORDS

I hereby authorize Kids Dental Experts® to provide:

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(Party to whom the records will be sent)

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(P.O. Box and/or Street Address)

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(City)

(State)

(Zip Code)

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(Telephone Number)

(E-mail Address)

with copies of records for:

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that the specific type of information to be disclosed may include a detailed report of examinations, treatment, prognosis, and copies of current x-rays. This consent is effective until Kids Dental Experts® receives notice that no additional information may be released. I understand that after records have been released to another provider, Kids Dental Experts® cannot be held accountable for their use.

Reason for transfer:

- I'm being referred.  
 I'm seeking a second opinion.  
 I have an insurance plan that mandates service be performed by another provider.  
 I have a new dental care provider.

Any comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(The signature of a parent or guardian is required if patient is under 18 years of age)

Relationship to patient: \_\_\_\_\_