



## Request to Transfer Records

I request and authorize \_\_\_\_\_ provide an electronic copy of all dental records for my children to the Doctor/Practice below as soon as possible:

Practice/Doctor Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Appointment Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Thank You!

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

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

**Authorization Expires One Year After It Is Signed**

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