Please read and sign this form. You can mail the payment or visit our office. Payment is required to cover the cost of duplication and/or copying patient records. You may pay via check, credit card, cashier's check, or come in the office and pay in cash. In accordance to California law all original records remain the property of Laser & Cosmetic Dentistry but patients are entitled to access to copies of all records. For additional information please refer to the following link: **http://mbc.ca.gov/consumer/complaint_info_questions_records.html#10**

Records Transfer Instructions

PLEASE READ CAREFULLY TO AVOID DELAYS!

We really do care about our patients, both past and present, and protecting our patients against harm is an important duty. Identity theft and other criminal activities seem to be on the increase and in an attempt to protect our patients; we are requiring **governmental identification** before releasing any patient records. Acceptable government issued identifications are a current California driver's license or a US Passport. Please **make a copy of both the front and back of your California Driver's license** and mail it along with your records transfer request. Of course, we prefer for you to personally come in and speak with us about transferring your records but we know that this is not always possible.

Please, **do not walk into the office without notice, or merely call, or email to request the x-rays transfer.** We will not leave scheduled patients who are in our dental chairs to duplicate records. We owe the patients who are in our office being treated the courtesy of attending to their care. It usually takes from **three days to a week** to have records reviewed and ready for processing to be sent by mail or e-mail and another three to five days for the US mail, if sent by mail, to get them to the new dentist's office or to your personal address. Please allow up to 15 days for us to process and send your records.

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____,
hereby authorize the doctor and staff of the Laser & Cosmetic Dentistry to release records or knowledge concerning my dental health to:

Your Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone number: _____

Fax Number: _____

Email Address: _____

OR

Doctor's Full Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone number: _____

Fax Number: _____

Email Address: _____

I specifically request that you release copies of:

- ☐ All x-rays **$45.00**
- ☐ All oral images **$60.00**
- ☐ All treatment notes **$20.00**

Signed (patient or guardian name) _____

Printed name (patient or guardian name) _____

We have included a **credit card authorization form**. Please fill it out completely and fax it with your records transfer request.

Agreement to debit my credit card for records transfer

Patient Name (print clearly): _____

Responsible Party Account: _____

I understand that these funds are for the costs of duplication, copying, printing, mailing, and e-mailing the dental records for the above named patient. In the case that there are any problems with my credit card payment, I agree to pay all collection costs and reasonable attorneys fees incurred in attempting to collect on this or any future outstanding account balances for the above named patient.

Circle one: Visa MasterCard

Credit Card Holder Name: _____

Billing Address: _____

_____

Credit Card Number: _____

Credit Card Expiration Date: _____

Card Verification Code: _____

I certify that this is my credit card and that I am legally authorized to give permission for its use. By signing this agreement and by providing a photocopy of my credit card, I hereby give my fully informed consent to copy and mail records for the above named patient.

I realize that once the services have been completed that these funds will be applied to the payment of these services and that I will not be entitled to any refunds. I agree not to dispute the resultant charges.

Cardholder Signature: _____ Date: _____

Cardholder Printed Name: _____

Laser & Cosmetic Dentistry will keep all information entered on this form strictly confidential.

IF YOU REFUSE TO PAY FOR THE DENTAL RECORDS, PLEASE SIGN THE FOLLOWING STATEMENT.

I, _____, refuse to pay for dental records. Even though the dental records will still be released to me, I understand that Dr. Nguyen has an option to send me to collection. I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on this or any future outstanding account balances.

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E-mail: office@laserandcosmeticdentistry.net ● http://www.laserandcosmeticdentistry.net/