Transfer of Records Information and Instructions

Patients who will be making appointments for the first time at DeForte Dentistry should complete the attached form and fax or mail to their prior dental office to initiate the transfer of their records.

FYI

The New Jersey State Board of Dentistry [http://www.njconsumeraffairs.gov/dentistry/](http://www.njconsumeraffairs.gov/dentistry/) provides the following information with respect to the transfer of dental records (emphasis supplied).

**Patient Records** are the personal work product of a dentist. Original records are required by Board regulations to be retained for a period of seven years from the last date of treatment. Dentists are required to maintain these original records, and are not permitted to release the originals. **However, copies of records and x-rays may be released at the request of the patient.** Requests for records should be made to the dentist in writing and specific instruction on where they are to be sent should be provided. Under the regulations, a dentist must provide the records within fourteen days of the written request. A dentist may charge a fee to recoup the cost of retrieving and duplicating the record. However, that charge may not exceed $1.00 per page up to $100 for the entire record, plus an additional charge of up to $10 to cover the costs of retrieval of the record. If x-rays need to be reproduced, a dentist may not charge any more than the actual cost of duplication. A dentist may not withhold records due to an unpaid bill, unless the dentist has not been paid for initial diagnostic services. If the dentist has affirmatively terminated a patient from the practice, the dentist may not charge for duplication of the record.
Transfer of Dental Records/X-rays

Date of Request: __________________________

Release:

( ) dental records
( ) x-rays

Patient Name:

1. ____________________________ DOB: ____________________________
2. ____________________________ DOB: ____________________________
3. ____________________________ DOB: ____________________________
4. ____________________________ DOB: ____________________________
5. ____________________________ DOB: ____________________________

E-mail (Digital X-rays Only) to drd@defortedentistry.com

Mail Records to:

DeFortе Dentistу
4 Swimming River Road
Lincroft, NJ 07738

Signature (patient, parent or legal guardian): _____________________________________________

Please Print Name: ___________________________________________________________________

By my signature above, I am authorizing the release of any records, including any radiographs that my family (patients listed above) or I may have at this office.