

## NT Family Dental PLLC, DBA Aspire Family Dental®

554 East Robinson St.  
N. Tonawanda, NY 14120  
Phone # (716) 695-1137  
Fax # (716) 260-1483

### Transfer of Your Records to Our Sister Dental Offices

Todd R. Levine, DDS owns all of the individual offices listed below. However, they are all legally separate dental companies. Most of the separate offices are doing business as Aspire Family Dental®. This form allows the above named company to transfer all of your records to the below named company.

"I \_\_\_\_\_ give permission to transfer all of my records to the following office listed below:

- All Care Family Dental PLLC, DBA Aspire Family Dental® (Lockport Office)  
Initial: \_\_\_\_\_
- Abcare Family Dental PLLC, DBA Aspire Family Dental® (Niagara Falls Office)  
Initial: \_\_\_\_\_
- Aspire Family Dental PLLC, DBA Aspire Family Dental® (Buffalo-Ontario Office)  
Initial: \_\_\_\_\_
- Total Care Family Dental PLLC, DBA Aspire Family Dental® (Buffalo-Hertel Office)  
Initial: \_\_\_\_\_
- Todd R. Levine DDS and Michael D. Hess, DDS (Lockport Office)  
Initial: \_\_\_\_\_
- All Care Family Dental PLLC, DBA Eastern Niagara Dentistry (Lockport Office) (57 Davison Ct., 2<sup>nd</sup> Location)  
Initial: \_\_\_\_\_

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AND DENTAL RECORDS TO BE TRANSFERRED TO THE DESIGNATED DENTAL OFFICE.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: \_\_\_\_\_ Print Name: \_\_\_\_\_

Source of Authority: \_\_\_\_\_