RECORDS REQUEST

I authorize the release of dental records and most recent x-rays for the patient(s) listed below:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Forward the records to:

_____

_____

_____

Email x-rays to: _____

(If no email address is written the x-rays will be printed and mailed to the address listed above)

Parent's Name: _____

Printed

Parent's Signature: _____ date: _____

If the patient is 18 years old or older they must request the records transfer.

Patient's Signature: _____ date: _____

Records will be sent out within 10 days of receiving this signed written request.

Reason for leaving the practice: _____

_____