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RECORDS RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

_____

_____

_____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Records being requested:

( ) Current radiographs ( ) Dental Health Status ( ) Reports ( ) Diagnostic Casts ( ) Treatment Record ( ) Charts ( ) Health History ( ) Prescription Records ( ) Photos () Other:

_____

_____

Patient Signature: _____Date: _____

Signature of Parent/Guardian: _____ Date: _____