PATIENT RECORDS REQUEST FORM

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Records Requested for Patient: ____

Date of Birth: ____________________

Send Records to: ____

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Request Records From: ____

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Records as indicated below will be forwarded unless otherwise noted by the patient:

________ Current Set of Radiograph Films

________ Last Cleaning & Exam On: ____________________

________ Periodontal Charting

________ Other Concerns: ____

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION:

Signature of Patient: ____

Signature of Authorized Representative: ____

Relationship to Patient:______________________________ Date: ____________________