Release of Dental Records Request

Patient Name: ____ Date: ____________

Responsible Party: ____

Contact Number: ____

What records are you requesting?

______ X-rays (If you need a specific x-ray please indicate which x-ray)
______ Treatment Records

Will the records be picked up or do you need them sent by mail?
If mail, where would you like the records to be sent? Please provide a name and address.

Responsible Party Signature: ____

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