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Patient Request Form

Disclosure of dental records will be made in accordance with the "Consent of Health Information" as signed by the patient or patient's guardian.

Patient Name:_____ ***Date:***_____

Address:_____ ***City:***_____ ***St***_____ ***Zip***_____

I hereby request a copy of my dental record a detailed below.

This request and authorization applies to:

_____ *Health care information relating to the following treatment, condition, or dates of treatment:*

_____

_____

_____ *Most recent FMX, Panorex and Bitewing X-Ray Perio chart*

_____ *All health care information*

This information will be disclosed for the following purposes: _____

_____

I request that dental records be sent to:

_____

_____

_____

Requestor Name:_____

Relationship to Patient: _____

Signature: _____

Date: _____