RECORDS REQUEST FORM

Patient's Name(Last, First)**:** _____

Home Address: _____

Telephone Number:

Home:_____Cell:_____

Date of Birth: _____/_____/_____

I hereby request the practice provide me with: **[Please check all boxes that apply]** ❑ My dental records ❑ My dental radiographs (x-rays)

Please check one of the following boxes:

❑ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ to _____. P

❑ I am interested in accessing or obtaining all the Requested Information maintained by the practice.

Please check one of the following boxes:

❑ I would like to have the Requested Information emailed to me at:

_____

❑ I would like to have the Requested Information mailed to me at:

_____

_____

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed Name of Personal Representative Relationship to Patient