RELEASE/REQUEST FORM of Patient Dental Records

1447 E Market St
York, PA 17403
(P) 717-845-2771 (F) 717-845-5907
Email: info@1447dental.com

Patient information whom dental records are being requested:

Name: ____

DOB: ____________________ Phone: ___________________

Address: ____

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Please provide a copy of the dental records as indicated below:

__x___Bitewing Xrays (if less than 1 year old)
__x___Full mouth or Panorex Xrays (if less than 5 years old)
__x___Periodontal Charting (PSR, full-mouth probings)
__x___Date of last periodontal treatment (if applicable)
_____Other: ____

***Please forward my requested dental information to the dentist listed above. I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release of the above requested information.**

Signature of patient or patient's authorized representative—please indicate relationship status if signed by anyone other than patient (i.e. Parent, legal guardian, etc.):

Signature: _______________________________________ Date: __________________