1447 Dental Associates
1447 E Market St, York, PA 17403, USA
(717) 845 2771
www.1447dental.com/

RELEASE/REQUEST FORM of Patient Dental Records

Patient information whom dental records are being requested:

Name: _____

DOB: _____ Phone: _____

Address: _____

_____

Please provide a copy of the dental records as indicated below to info@1447dental.com:

__x___Bitewing Xrays
__x___Full mouth and/or Panorex Xrays
__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: _____