Advanced
FAMILY DENTISTRY
DENTISTRY WITH YOU IN MIND

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RELEASE OF DENTAL RECORDS

Patient's Name _____

Date of Birth _____

Relationship to Patient _____

If not the pt., is individual legal guardian or listed on pt.'s HIPAA release? YES NO

Describe the records you wish to access: _____

_____

____ I wish to pick up the records in person

____ I wish to have the records sent electronically to:

Name of dental office: _____

Email: _____

Phone number: _____

*WE DO NOT RECOMMEND SENDING PATIENT INFORMATION IN AN UNENCRYPTED EMAIL.

_____ _____

Advanced Family Dentistry Team Member Patient/Pt's Representative

_____ _____

Date Date