courtsidedental
FAMILY & AESTHETIC DENTISTRY

RECORDS RELEASE REQUEST

Date _____

I authorize the release of dental and medical records relevant to dental treatment, or copies of such, and request that they are transferred to:

To (Dr. name): _____

Address _____

City _____ State _____

Zip _____ Phone _____

Please print the patients name(s) or records to be released:

_____ _____

_____ _____

_____ _____

Reason for leaving:

_____

_____

New (forwarding) address and phone of transferring patient:

Address _____

City _____ State _____

Zip _____ Phone _____

Signature _____

(Patient, Parent or Guardian)