Request for Release of Patient Records

Please complete this form on-line, then PRINT and SIGN the completed form to bring or mail to our office.

The undersigned acknowledges their lawful authority to request the release of their dental records. The undersigned and listed patient has hereby requested the transfer of said records, and we hereby request that you release the following patient's records:

Date ______________________

Patient Name(s)

Last	First	Middle	Date of Birth
Last	First	Middle	Date of Birth
Last	First	Middle	Date of Birth
Last	First	Middle	Date of Birth
Last	First	Middle	Date of Birth

Patient signature: ______________________ Date ______________________

Guardian signature (if applicable) ______________________ Date ______________________

Contact Information

Home address ______________________ Home Tel ______________________

City ______________________ ST __________ Work Tel ______________________ Cell ______________________

Zip ______________________ E-mail address ______________________

Previous Dentist

Practice Name ______________________ Dentist Name ______________________

City ______________________ ST __________ Telephone # ______________________

This record should include a written explanation of all treatment rendered with the dates of treatment, and all readiographs which were taken while under your care.

☐ Please forward records to the above listed patient's address

☐ Please forward to:

Highpoint Dental Medicine, P.C.
200 Highpoint Drive, Suite 220
Chalfont, PA 18914

Thank you for your prompt help and cooperation with this matter.