Corporate Office:
483 Middle Turnpike West
Suite 309
Manchester, CT 06040

860-730-6020

Patient Record Release Request Form

Patient Name: ____

Address: ____

____

Office: ☐ **483 Middle Tpke W Manchester, CT (Main)**

TO WHOM IT MAY CONCERN

I authorize the release of dental records and radiographs (x-rays) relevant to dental treatment or copies of such and I understand that I will be responsible for my records.

DATE: ____________________________________

PATIENT: __________________________________

DATE OF BIRTH: ____________________________

ACCOUNT ID: ______________________________

Date of Last Exam: _________________________ Date of Last Prophy: ___________________

Date of Last Full Mouth X-Rays (FMX): ___________ Date of Last Bite Wings (BW): _____________

Please contact our office if we can be of further assistance. If requesting unencrypted email, you must understand that it is possible that email could be intercepted.

Signature of Patient (Parent if minor): _______________________________ Date: ___________________

---For Office Use---

☐ Approved for Release ☐ Disapproved for Release (Reason to follow)

Date of Release: ________________________ Initials of Person Releasing Information: _______________

Method of Release: ☐ Copies handed directly to patient ☐ Email ☐Mail ☐CD ☐ Flash Drive

Scan this into patient document Center ☐