



# Dental Studio

OF PALM HARBOR

## RECORDS RELEASE

I, \_\_\_\_\_, with date of birth \_\_\_\_\_, request the release of dental records relevant to dental treatment, or copies of such, to be sent or transferred to:

Myself via e-mail: \_\_\_\_\_

or mailing address:

Dental Office:

Other person: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

E-mail or mailing address: \_\_\_\_\_

Records being requested:

Recent Radiographs     Dental Photos

Treatment Plans     Clinical notes

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_