PATEINTS RECORDS REQUEST FORM

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Name of Patient Whose Record is Requested_____

DOB_____Phone_____

Address_____City/State/Zip_____

Records to be sent to:

_____

_____

_____

A copy of the records as indicated below will be forwarded unless otherwise noted by patient:

- Current set of Radiographic Films
- Last Cleaning and Exam was on_____
- Other Concerns or Uncompleted Treatment

_____

_____

Signature of Patient_____

Signature of Authorized Personal Representative_____

Relationship to Patient_____

Date: _____

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under a circumstance that does not require patient authorization. You, the recipient are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law