

**Request for Release of Patient Records**

The undersigned acknowledges their lawful authority to request the release of a patient’s records. Wood Family Dentistry requests diagnostic quality duplicates of current radiographs (full series or panorex radiograph less than 5 years old, and bitewing radiographs less than one year old). In addition, the undersigned and listed patient, has hereby requested the transfer of said records and Wood Family Dentistry hereby requests that you release the following patient’s records:

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Phone/Fax/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Guardian Date

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

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Frederick T. Wood, DDS Date

Brittany Amor, DDS

Wood Family Dentistry thanks you in advance for your help and cooperation in the future care of our patient. Please email radiographs and any significant treatment notes to the following email address:

FrontDesk@WoodFamilyDentist.com