REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. We request diagnostic quality duplicates of current x-rays: (Full series or panorex x-ray less than 5 years old and bitewing x-rays less than one year old). In addition, 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:

Patient's Name: _____

Date of Birth: _____

Previous Dentist: _____

Dentist's phone/fax: _____

_____ Date:_____
Signature of patient or guardian

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

_____ Date:_____
Frederick T. Wood, D.D.S.

We thank you in advance for your help and cooperation in this matter.

For digital x-rays, email to: susan.wcfd@gmail.com

For questions, please call: 480-839-0433

Submit