REQUEST FOR RELEASE OF PATIENT RECORDS

Requesting records from: ____

Phone (____) ______-_____________ **Fax (____) ______-_____________**

Patient's Name: ______________________________ **DOB:** _________________________

Additional family members: *(Adults must each sign their own release form)*

____ DOB: __________________________

____ DOB: __________________________

____ DOB: __________________________

____ DOB: __________________________

Signature: ___________________________________ **Date:**___________________________
(of Patient, Parent, or Guardian)

*************************To Be Completed By Previous Dental Office*************************

Incomplete treatment: ____

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BWX 2/4 Dated: ________________________ **Panorex Dated:** ______________________

FMX Dated:____________________________ **Fluoride Tx Dated:** ___________________

Please EMAIL this completed form and records to **xray@oronodentalcare.com**

Records may also be mailed to:

Orono Dental Care
2765 Kelley Parkway, Suite 140
Orono, MN 55356
Phone: 952.449.9494/ Fax: 952.449.9499

If there are no current records, please indicate so and fax this form to 952-449-9499. Thank you!