DENT
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Medical Record Request

I authorize the disclosure of my medical information as described below. I understand that there is a fee of $0.75 per page for acquiring records not being sent directly to another physician or medical facility. Requests are processed by a copy service and are mailed out 7-14 business days from receipt of this request. No records are to be picked up at Dent.

Patient Name: ______________________________________ Date of Birth: ____________

Patient Address: ____

____

Party Providing Information

____

Address:

____

____

Phone: ___________________________

Fax: ____________________________

Party Receiving Information

____

Address:

____

____

Phone: ___________________________

Fax: ____________________________

Reason for Release: ____

Please Check All That Apply

☐ Entire Medical Record ☐ Diagnostic/Imaging Report ☐ Laboratory Report ☐ Progress Report

☐ Other: ___________________________________

____ ________________

Signature of Patient or Patient's Representative Date

____

Relationship to Patient

Inter-Office Use Only

Provider Signature (if applicable)____

Initials of Staff Member ____________

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