Patient Record Release Request

Patient Name Date: l

 (print)

I, hereby request the following:

 (Patient or Patient Representative)

* To receive a paper copy of my record
* To receive an electronic copy of my record
* To have my records transferred to another office

***Belmont Dental Group requires any person requesting a copy of their records in any format desired to submit the request in writing. If for any reason the format requested cannot readily be produced, the patient or patient representative will be notified of such and other accommodations will be made.***

Reason for request: l

Address to forward records:

 L

 L

 L

Email: l

Phone Number: l

Fax: l

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_