Patient Record Release Request

Patient Name _____ Date: _____

(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: _____

Address to forward records:

_____

_____

_____

Email: _____

Phone Number: _____

Fax: _____

Patient Signature: _____

For office use only

Employee signature: _____ Date: _____