donald **wurtzel** dds pc

Authorization for Release of Dental Records

Today's Date ________________

Patient (s) **Name and Date of Birth:** ____

____

Patient (s) **Current Address**: ____

____

Phone # __________________________

Requesting: Records and x-rays _________ Pano Only _________ x-rays only ___________

Records to be: Mailed _______________ Email _____________ **or** Picked up in office _________________ on __________________

I authorize Wurtzel Family Dentistry to release my records to:

Dr's Name: _______________________________________ Phone: _________________________

Address: ____ Fax: __________________________

____

Email Address: ____

____

Please request my records from:

Dr's Name: ______________________________________ Phone: ___________________________

Address: ____ Fax: ____________________________

____

Email Address: ____

Reason for request:

Referred out: ____________ Moving: __________ Other: ___________ (explain) __________________________________

____

____

Signature of Patient or Guardian: ____

Staff Initials: ______________ Date records mailed or picked up: _______________________

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