Harry Randel DMD & Associates
9892 Bustleton Avenue, Suite 304
Philadelphia, PA 19115
215.673.0123

REQUEST FOR RELEASE OF PATIENT RECORDS

To: PHILADELPHIA OFFICE

To Whom It May Concern:

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

PATIENT'S NAME AND/OR ENTIRE FAMILY:_____

DATE(s) OF BIRTH:_____

ADDRESS: _____
_____

Please include legible copies of the most recent panoramic x-ray, the most recent full mouth x-ray series, most recent bite wing x-rays, and all progress notes, chartings, treatment plans, medical and dental histories. Any other records, which would be helpful in continuing dental treatment, should be included.

The Undersigned acknowledges receipt that they are lawfully authorized to receive said records:

In compliance with applicable State Board regulations, please copy my dental records and send them within 14 days to:

Harry Randel DMD, PC
9892 Bustleton Avenue, Suite 304
Philadelphia, PA 19115
215.673.0123
hrandeldmd@verizon.net

Patient's (s) signature: _____ (Parent if under age 18)

Date:_____

We Thank You in advance for help and cooperation in this matter!