DARBY CREEK DENTAL

DAVID W. CLEVELAND, DDS
DERIC R. BUDENDORF, DDS
KYLE S. WYLDE, DDS

REQUEST FOR RELEASE OF PATIENT RECORDS

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: _____ DOB: _____
_____ _____
_____ _____
_____ _____

Previous DDS name, address, office phone number, and/or e-mail address:

_____
_____
_____
_____

_____ _____
Patient Signature or Guardian (if applicable) Date

Please send or e-mail the requested records to the address below:

Darby Creek Dental
137 Damascus Road
Marysville, OH 43040

dentist@darbycreekdental.com

We thank you in advance for your help and cooperation in this matter. If you have any questions please call our office at 937-644-8822.

Sincerely,

Darby Creek Dental, Inc.