DENTAL RECORD RELEASE FORM

DATE: _____

TO: DARBY CREEK DENTAL
137 Damascus Road
Marysville, OH, 43040
O: (937) 644-8822
F: (937) 644-1621
E-mail: dentist@darbycreekdental.com

PLEASE RELEASE: ( ) CURRENT X-RAYS
( ) COPY OF PATIENT RECORDS

TRANSFER RECORDS TO:

NAME OF DENTAL FACILITY: _____
STREET ADDRESS: _____
CITY, STATE & ZIP: _____
FACILITY E-MAIL: _____

NAME OF PATIENTS & BIRTHDATES:

(*PRINT*): _____
_____
_____
_____
_____

REASON FOR TRANSFER (*MUST BE COMPLETED*):

( ) RELOCATION
( ) NOT SATIFIED WITH TREATMENT RECEIVED
Please Explain: _____
( ) OTHER
Please Explain: _____

I RELEASE THE ABOVE FACILITY FROM ANY LAWS RELATED TO DISCLOSURE OF CONFIDENTIAL OR PRIVILEGED INFORMATION.

SIGNATURE: _____
DATE: _____