Great Woods Family & Cosmetic Dentistry
792 South Main St Suite 24
Mansfield, MA 02048
Ph:508-339-4171
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DENTAL RECORDS RELEASE FORM

In order for records or radiographs to be transferred or copied this form must be completely filled out and submitted with a $25.00 fee. We have 14-21 days to complete this process once completed form and payment is received.

PATIENT NAME: ________________________________ DOB: _________________

ADDRESS: _____________________________________ CITY,STATE,ZIP: _______________

PHONE: __________________________ EMAIL: ________________________________

PLEASE FORWARD MY RECORDS TO THE DOCTOR'S ADDRESS BELOW:

PRACTICE NAME: ____

ADDRESS: _____________________________________ CITY, STATE, ZIP _____________

PHONE: __________________________ EMAIL: ___________________________________

THIS REQUEST AND AUTHORIZATION APPLIES TO THE FOLLOWING:
___ DENTAL INFORMATION REGARDING THE FOLLOWING TREATMENT, CONDITION, DATES:
____

___ ALL DENTAL INFORMATION

___ OTHER: ____

_____ YES ____ NO I AUTHORIZE THE RELEASE OF ANY RECORDS REGARDING DRUG, ALCOHOL, OR MENTAL HEALTH TREATMENT TO THE PERSON(S) LISTED ABOVE.

REASON FOR RECORD RELEASE: ____

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SUGGESTIONS/COMMENTS:
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PATIENT SIGNATURE DATE