Patient Records Access Request Form

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I hereby request a copy of my dental record as detailed below:

- ☐ Full dental record held by this office
- ☐ Dental record for the period _____ through _____
- ☐ A specific portion/section of the record as follows:

_____

_____

_____

I understand that, unless otherwise provided by law, the charge for this record will be $0.25 per page for each page copied. I agree to pay this charge in full at the time I receive the copy of the record.

Patient Name:	
Name:	Relationship:
Signature:	Date: