



RECORDS RELEASE FORM

REQUEST FOR RELEASE OF PATIENT RECORDS AND RADIOGRAPHS

Please send to our office the most recent bitewing, panoramic and/or intraoral full mouth radiographs.

By the patient signature below you are authorized to send these originals or diagnostic duplicates and you are released from any and all laws related to disclosure of confidential and privileged information.

TO FORMER DENTIST: IF YOU HAVE DIGITAL XRAY FILES (IN JPEG FORMAT), PLEASE SEND TO office@allegandental.com. This is preferred to a printed copy.

We thank you in advance for your help and cooperation in this matter. Please mail to the below address, fax to 269-686-0347 or email to office@allegandental.com.

Patient Signature

Guardian (if applicable)

Date

Evan A. Be D.D.S.
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