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: _____________

Address: ______________________________________

____

Patient Signature:____

Date: _________________________

Guardian (if applicable):______________________________________

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

Provider_____________________________________

Signature:______________________________

Date: __________________________

Hidden Valley Dentistry
5020 Grandin Rd Extension SW
Roanoke, VA 24018

We thank you in advance for help and cooperation in this matter.