RELEASE/REQUEST
of Patient Dental Records Form

1732- 214th St. SE
Bothell, WA 98021
(P) 425-485-2942 (F) 425-398-5933
Email: info@crystalspringsdental.com

Name of Patient whose dental record is being requested:_____
D.O.B.:_____Phone:_____
Address:_____City/State/Zip:_____

Please provide a copy of the dental record as indicated below:

_____Bitewing Xrays (If less than 1 year old)
_____Full Mouth or Pano Xrays (If less than 5 years old)
_____Periodontal Charting
_____Date of last Root Plane/Scale (if applicable)
_____Other:_____

*Please forward my requested dental information to the Dentist listed above. I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release of the above requested information only.

_____
Signature of patient or patient's authorized representative
_____**Date:**_____
Relationship or status if signed by anyone other than patient (Parent, legal guardian, etc.)