Request for Dental Records

Patient Name: ____

Birthdate: ____

Address: ____

Records Needed: ____

____

Patient Signature (or parent/guardian): __________________________

I hereby request my records to be released:

- ☐ **TO**
- ☐ **FROM**

Handcrafted Dentistry
4208 South Alston Ave, Suite 100
Durham, North Carolina 27713
info@handcrafteddentistry.com

- ☐ **TO**
- ☐ **FROM**

Office Name: __________________________________

Address: ______________________________________

Phone #: ______________________________________

Fax #: ____

Email Address: _________________________________