

**REQUEST FOR RELEASE OF DENTAL RECORDS**  
**from**  
**Children's Dental Village**

**This form may be printed and mailed to the address below or faxed to our office, 480-838-0092**

Thank you for completing this records request. All requests for records transfers to another provider or for your own files will be processed within seven (7) days of receipt of the request.

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

I request copies of the following dental records:

- Most recent dental records & x-rays to be forwarded to another dentist (see name and address below).
- Current x-rays only (Panorex within 3 years and Bitewings/Periapical films within one year to be forwarded to another dentist).
- Records for my own files to include:
  - X-rays (\$5.00 copying fee per panorex or set of individual films)
  - Dental records (copying fees may apply)
  - Billing records/ledger history

Records requests will be processed within seven (7) business days. I request the records be:

- Mailed to Dentist, Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
- Mailed to home address: \_\_\_\_\_  
\_\_\_\_\_
- Available to be picked up within **seven days** at Children's Dental Village during regular business hours.

Records requested from:  
Children's Dental Village  
7360 S. McClintock Drive  
Tempe, AZ 85283

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Printed name of parent or guardian

Date

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Signature of parent or guardian

Relationship