

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

Printed name of parent or guardian

Date

Signature of parent or guardian

Relationship