

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

Thank you for completing this request for records and returning via mail, email or fax (see below for info).  
All request for record transfers will be processed within seven (7) days of receipt of the request.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please release copies of the following dental records:

- ☐ Most recent dental records and X-rays forwarded to another provider (see name and address below)
- ☐ Current X-rays only forwarded to another provider (see name and address below)
  - ☐ Panorex with 3 years
  - ☐ Bitewings/Periapical films within one year
- ☐ Records for personal files to include
  - ☐ X-rays (\$5 copying fee per panorex or set of films may apply)
  - ☐ Dental Records
  - ☐ Billing records/ledger history Date range: \_\_\_\_\_

Please forward the above information to the following:

- ☐ Mailed/Emailed to Provider Name: \_\_\_\_\_  
Mailing Address or Email: \_\_\_\_\_  
\_\_\_\_\_
- ☐ Mailed/Emailed to Parent/Guardian/Patient  
Mailing address or Email: \_\_\_\_\_
  - ☐ Yes, I acknowledge and understand the risks involved in email/mail communication and consent to receiving information, including x-rays, via email/mail.
- ☐ Available to be picked up within **seven days** at Children's Dental Village during regular business hours.

Records Requested By:

Printed name of parent/guardian	Date
Signature of parent/guardian	Relationship

**Children's Dental Village**

7360 S. McClintock Drive

Tempe, AZ 85283

P: 480-838-6949

F: 480-838-0092

E: [Records@childrensdentalvillage.net](mailto:Records@childrensdentalvillage.net)