Sunrise Smiles Dentistry
(208) 497-0049
2641 25th East. Ammon, ID 83406
sunrisesmilesid.com

PATIENT RECORD RELEASE FORM

Name of Patient whose Dental Record is Requested: ______________________________

DOB: ____________________PHONE:__________________

ADDRESS:________________________CITY/STATE/ZIP________________________

PLEASE PROVIDE A COPY OF THE DENTAL RECORD AS INDICATED BELOW:

____Perio charting
____Bitewing X-rays (If less than 1 year old)
____Pano X-ray (If less than 3 years old)
____Other:____

PLEASE FORWARD MY REQUESTED DENTAL INFORMATION TO:

Name of new Dentist: ______________________________

Address of Dentist: ________________________________

City, State, Zip: __________________________________

Office Phone: ____________________________________

Office Email *required for X-rays: _____________________________

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 the patients authorized representative Date Signed

____

Relationship or status if signed by anyone other than patient (parent, legal guardian, etc.)

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