Midland Park Family Dentistry

REQUEST FOR RELEASE OF PATIENT RECORDS

Previous Dentist Information:

Name:

Address:

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby request that you release the following patient's records.

Patient's Name:

Date of Birth:

Address:

Authorized Recipient:

Midland Park Family Dentistry
662 Godwin Avenue
Midland Park, NJ 07432
(201) 447-5555
****EMAIL PREFERRED: team@midlandparkfamilydentistry.com****

_____ Date: _____
Signature

_____ Date: _____
Guardian (if applicable)

We thank you in advance for your help and cooperation in this matter.