9750 NE 120th Pl
Ste 7/8
Kirkland WA, 98034

Patient Dental Records Release form

Name of patient: ______________________________ Date of Birth: ______________

Please Provide a Copy of the records as indicated below:

____ Bitewing X-rays (if less than 1 year old)

____ Full Mouth and/or Pano X-ray (if less than 5 years old)

____ Perio Charting

____ Dates of SRP completed.

____ Other: _____________________________

Please Forward my requested dental information to (select one):

____ Manson & Chi Dentistry
office@mansonandchidentistry.com ~ **Please send X-rays as <u>individual films</u> in jpeg or Dexis format.**

____ To myself ~ records will be sent encrypted & email will only be valid for 30 days.
Email: ______________________

____ Name of New Dentist: ______________________________
Office Phone:____________________________________
Office Email: _____________________________________

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.

____

Signature of Patient/Parent/Guardian **Date**

____

Relationship & Printed name if other than patient signed above (parent/legal guardian etc.)