

RECORD RELEASE AUTHORIZATION FORM
Transfer and/or Moving (circle one)

TO: Collegetown Family Dental
324 Dryden Road
Ithaca, New York 14850

FROM: _____
Print patient name in full

Patient date of birth

DATE: _____

If transferring - please let us know why you have decided to leave our dental practice:

If moving - please let us know your new contact information:

Address: _____

City/State/Zip: _____

Phone/email: _____

Record Release Authorization:

I hereby authorize and request you to release a copy of my complete history and records, including copies of current radiographs, in your possession from the beginning of treatment to my most recent treatment.

I understand that copied records can only be released to me and that I must come in and sign receipt of said copies.

I do understand that there is a \$10.00 copy fee for this service.

I will pick up my records on the following date: _____ (minimum ten days from request).

*Patient signature (only an original signature is acceptable)

All patients 18 years of age or older must request their own records.

*Parent or Guardian (only an original signature is acceptable)

For patients under the age of 18.

***Please note, this form must be returned to our office with your original signature. Faxed copies are not acceptable. Thank you!**

RECORD RELEASE AUTHORIZATION FORM
Transfer and/or Moving (circle one)

TO: Fall Creek Family Dentistry
501 North Cayuga Street
Ithaca, New York 14850

FROM: _____

Print patient name in full

Patient date of birth

DATE: _____

If transferring - please let us know why you have decided to leave our dental practice:

If moving - please let us know your new contact information:

Address: _____

City/State/Zip: _____

Phone/email: _____

Record Release Authorization:

I hereby authorize and request you to release a copy of my complete history and records, including copies of current radiographs, in your possession from the beginning of treatment to my most recent treatment.

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