REQUEST FOR DENTAL RECORDS

I, _____

of (your address)_____

request access to or give consent to **SMILE CARE LATROBE** to access the entire contents of my dental records or the following documents as listed below.

I understand that I will not be permitted to remove the contents of my dental record from the premises of the dental practice, nor will I be permitted to alter of erase information contained In the dental record.

I understand that I will be permitted to obtain copies of some or all of the contents of my dental record. Where copies are requested, a fee may be applicable. Further, I understand that copies may not be available to me as soon as practicable following the inspection.

WE ARE REQUESTING A COPY OF: Notes and X-rays.

Previous Practice name: _____

Practice address: _____

Signature of Patient: _____

Date of Birth: _____

Dated: _____

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