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.

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!**