Records Release Request

I hereby authorize and request _____ to release my dental radiographs, dental records and medical records pertinent to my dental treatment, or copies of such, to:

D'Andrea and Pantera D.M.D., PC
2675 Whitney Avenue
Hamden CT, 06518
Phone: 203-288-0951
Fax: 203-281-1167
Email: dpdentistry@yahoo.com
www.dpmgeneraldentistry.com

Please indicate the reason for record request below:

- ☐ This is a permanent dental office change (please note reason for change) _____
- ☐ This is a request for a specialist visit or a second opinion

- ☐ I understand that according to state law, a reasonable fee may be assessed for the copying of my records.

Patient Name(s) (please print): Date:

Patient/Parent Signature: