REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

Patient Name:____

DOB: ____

Address: ____

Phone Number: ____

Patient Signature:___________________________________**Date:**______________________

Guardian (if applicable) Signature: ______________________**Date:**______________________

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

Hicks Dental Group

Date: _________________________

By:____________________________

We thank you in advance for your help and cooperation in this matter.

Hicks Dental Group
108 Whipple Street
Prescott, Arizona 86301
928-445-6030
FAX 928-445-6085
E-mail hicksdental@cableone.net

Sent To:________________________________