

DENTAL RECORDS RELEASE FORM

Stephen A. Lawrence, DDS
785 Grand Ave., Suite 206
Carlsbad, CA 92008

Dear Dr. Lawrence:

I understand that, because my dental records are confidential, I need to give specific authorization to have any of my dental record information released.

I am requesting that the below listed information be released from my dental records. I wish to have this information sent to the dentist listed below.

I understand that there is a processing fee for this service and that it is payable at the time of this request.

I authorize the release of:

<input type="checkbox"/>	Copies of Digital X-rays	no charge
<input type="checkbox"/>	Copies of all my older dental X-rays	\$10.00
<input type="checkbox"/>	Summary of my whole dental record	\$15.00
<input type="checkbox"/>	Summary of treatment and X-ray of a specific tooth/or teeth	\$10.00

Thank you.

Sincerely,

Signature

Patient (printed)

Address

Dentist

Address