Dental Records Request Form

Patient Name: ________________________________ **Date of Birth:** ____________

I ____________________________, hereby request the doctor and staff of:
(Patient's Name or Legal Guardian)

____
Name of Healthcare Provider

Address: ____

City: __________________ **State:** _____ **Zip Code:** ___________ **Email:** ______________________________

Fax: _______________________________ **Phone:** ______________________________

to release records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Records being requested:

( ) Current Radiographs
( ) Diagnostic Casts
( ) Health History
( ) Treatment Plan
( ) Dental Health Status
( ) Treatment Record
( ) Prescription Records
( ) Billing Records
( ) Reports
( ) Charts
( ) Photos
( ) Other: ______________________

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED: ____

Delivery Options: ( ) Mail ( ) Email ( ) Fax ( ) Pick-Up

Send to: **Dr. Spencer Zaugg, Family & Implant Dentistry**
176 South 32nd St. West, Suite #2
Billings, MT 59102
Phone: 406-655-0887
Fax: 406-969-3781
drspencerzaugg@gmail.com

Signature of Patient/ Legal Guardian:

____ ______________________
Name of Patient or Legal Guardian (Print) Date

____
Signature of Patient or Legal Guardian

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Relationship to Patient