Request for Records

Patient's Name (print): _____ Date of Birth: _____

I want **NorthPark Dental Group** to send the copy of the requested radiographs to:

Name: _____

Address: _____

_____

If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!):

_____@_____

We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want an unencrypted email sent, despite the risks, and do not hold NorthPark Dental accountable for any liability

Fees: Our practice charges a reasonable, cost-based fee for copies of patient information, and for postage to mail records if requested.

If this request is by a patient:

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Print the Name of the Personal Representative: _____
Relationship to the Patient: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative: _____ Date: ____

Questions?
Please contact our office if you have any questions about your request.

For dental office use only:

- Request for records denied (attach written denial).
- Request for records approved.
  If approved, describe below when and how the records were provided.
  _____