BROOKS
FAMILY DENTAL

Request for Release of Patient Records

The undersigned acknowledges their lawful authority to request the release of patient dental records including dental chart history and X-rays. The undersigned and listed patients have hereby requested the transfer of said records and we hereby request the release of the following patient's records:

_____ _____

Name Date

_____

Signature

Reason:

Referral Moving Other:

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

Brooks Family Dental

Please email records to:

info@BFamDental.com

548 W Plumb Ln Ste A

Reno, NV 89509

P 775-329-9534 F 775-329-6751