Hudson Highlands Dentistry LLC
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PATIENT RECORDS ACCESS REQUEST FORM

I hereby request a copy of the dental record and x-rays to be released from:

_____

_____

_____

_____

Patient Name: _____

Date of Birth: _____

Name (if Parent or Guardian): _____

Relationship: _____

Signature: (Patient or Parent / Guardian) _____

Date: _____

Office Use Only

Date Sent _____

Initial of clerk _____

Please return a copy of this request along with the dental record and x-rays to our office at your earliest convenience. Thank you for your prompt attention to this request.