KOBODA DENTAL

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Patient Name: _____ Date of Birth: ____/____/____

REQUEST FOR COPY OF DENTAL RECORDS

I, _____, am requesting a copy of my dental records from KOBODA DENTAL.

I would also like to request a copy of dental records for the following family members:

_____ _____

_____ _____

_____ _____

I would like the dental records to be sent directly to the following dental office:

Name of Dental Office: _____

Name of Dentist: _____

Address of Dental Office: _____

Phone # of Dental Office: ( ) _____- _____

Email Address of Dental Office: _____

I understand that the original dental records are the property of KOBODA DENTAL, and I agree to accept a copy of these dental records.

_____ _____ ____/____/____

Signature of Patient/Guardian who is authorizing the release Relationship to Patient Date