REQUEST OF A COPY OF DENTAL RECORD

I (*your name***), _____HEREBY REQUEST ACCESS TO DENTAL X-RAYS**
Today's Date: _____

Patient's Name (Please include middle initial)
_____

Patient's Birth Date_____

Patient's Phone Number
(Home)_____(cell)_____

Patient's Current Address
_____
_____

Please choose one: ___ Records requested for Personal/Referral Use
___ Seeing another provider
If you are requesting your records due to seeing another provider please provide the Reason You are Leaving Our Office:
_____

X-Rays to be sent to:

_____
_____
Office Name Doctor(s) Name
_____
_____
Office Address-City/State/Zip
_____
_____
_____
Email Address

Please allow (3) three business days for records to be made available and/or forwarded to the requested provider.

Please return this form via either fax or email to:
Via email: appointments@atlanta-smiles.com or Via Fax: 770-828-0234

CHARGES: Cone Beam CT Scans: I understand that there is a $50 fee for a copy of CT Scans provided to me and that this will be due at the time of receipt and/or mailing and that any CT mailed will also incur a mail fee of $4.95.