Practice Policy Forms

Release of Records

Please provide me with copies of all of my dental treatment records, including notes, medical prescriptions, diagnostic X-rays, and any other materials. I understand that original records and X-rays are your property. I agree to accept and pay reasonable fees for such copies.

Patient Name: _____

Patient Signature: _____

Date: _____

This sample document contains information that you may use or modify for your practice's needs. Your needs may vary based upon the laws in your state. This document does not constitute legal advice.