Patient Release of Dental Records Form

(Please Print or Type)

I, _____, do hereby request and give my permission to release my dental records from the following Dental Office:

(Patient and/or Guardian's name)

Office Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone Number:_____

The Dental Records as listed on the bottom of the page are to be released to:

Name: L. Tim Choy, DMD

Address: 1733 Woodside Road, Suite 100

City: Redwood City **State** CA **Zip** 94061

Phone Number: (650)716-4888

Fax Number: (650)716-4966

Email (preferred method): info@drtimchoy.com

_____ _____

Printed Patient/Guardian Name Date of Birth

_____ _____

Patient or Guardian Signature Today's Date

Copies of the following are specifically requested:

- ☐ **Progress Notes**
- ☐ **Letters/Reports to/From Specialists**
- ☐ **Periodontal Charting**
- ☐ **Radiographs**
- ☐ **Medical history forms**