PATIENT RECORDS REQUEST FORM

Classic Dental
4267 W. Lake Mary Blvd
Lake Mary, FL 32746
(407) 302-7774 / (407) 302-5651

Name of Patient Whose Record is Requested ____

DOB ____________________________ Phone ____

Address ______________________________ City/State/Zip ____________________________________

Please provide a copy of the record as indicated below:

☐ The full health record maintained by this provider/practice

☐ The health record for the following time frame _________________ through ___________________

☐ A specific section of the health record as described below:

____

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☐ A summary of the information requested above is adequate to fulfill this request.

☐ As permitted by federal and state law. I understand that a fee of _______ cents per page will be charged for copying the records along with clerical fee of _________. In addition, a fee of __________ will be charged for any duplicate of x-rays.

Signature of Patient ____

Signature of Authorized Personal Representative ____

Date _________________