

# 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_