

PATIENT RECORDS REQUEST FORM

Classic Dental
158 Lookout Place
Suite 101
Maitland, FL 32751
(407) 682-7774 / (407) 628-5651

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 _____