Request for Incoming Records

Patient Name: _________________________________ DOB: __________________

Type of Records Requested:

- X-rays
- Transactions/Services Performed
- Periodontal and Clinical Charting
- Other: ____

Reason for Request:

- Second Opinion
- Changing Dentist
- Other/Reason (Optional): ____

Records Release Method:

- E-Mail to **coalcitydental@aol.com** (preferred)
- Mail to Provider at 645 E. Division St., Coal City, IL 60416
- Patient Pick-Up in Office
- Mail to Patient (Address): ____
- *E-mail to Patient (Address): ____
- Other: ____

Signature: ________________________________ Date: ______________________

(If not the patient): Name: _____________________ Relationship: _______________

*E-mails are not encrypted; information could be viewable by a third party. This method of transmission is not available for full legal copies, as these may contain sensitive personal and financial information.

• Coal City Dental Center • 645 E. Division • Coal City, IL 60416 •

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