REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient have hereby requested the transfer of said records, and we hereby request that you release the following patient's records:

Patient's Name:

_____

Patient Signature:

_____

Guardian (if applicable)

_____

DATE:

Narlis Dental
913 Ridgebrook Road Suite 206
Sparks, MD 21152
Ph 410 472 9650
Fax 410 472 9653

We thank you in advance for help and cooperation in this matter.