ADVANTAGE DENTAL

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

DIRECTIONS: PLEASE PRINT CLEARLY AND PROVIDE ALL INFORMATION REQUESTED. ALLOW FIVE (5) BUSINESS DAYS FOR PROCESSING OF REQUEST. EACH INDIVIDUAL REQUEST MUST BE COMPLETED AND SIGNED BY THE PATIENT UNLESS THIS IS FOR A MINOR.

Patient Name	
Office Location	

I AM REQUESTING THAT MY DENTAL RECORDS BE SENT TO THE ADDRESS LISTED BELOW. I UNDERSTAND THAT THIS REQUEST REQUIRES MY SIGNATURE AS AN INDICATION OF CONSENT FOR THE OFFICE TO RELEASE A COPY OF MY X-RAYS. I HAVE ALSO BEEN INFORMED AND UNDERSTAND THAT IN ACCORDANCE WITH MY DENTAL PLAN BENEFITS THERE MAY BE A CHARGE FOR THE DUPLICATION OF FILMS. RECORDS ARE LEGALLY CONSIDERED THE PROPERTY OF THE DENTAL PRACTICE AND REMAIN UNDER THE GUARDIANSHIP OF THIS OFFICE UNTIL NO LONGER REQUIRED BY THE STATE LAWS OF VIRGINIA; HOWEVER, AS A PATIENT I HAVE A RIGHT TO A COPY OF MY X-RAYS. PLEASE COMPLETE THE NAME AND ADDRESS FOR THE DOCTOR WHERE THE RECORDS ARE TO BE SENT.

Doctors Name	
Building Name	
Street Address	
Suite Number	
City, State & Zip	
Doctors E-Mail	
Patients Signature	

While you are not obligated in any way to provide us with a reason, we would appreciate knowing more about your decision to leave our practice. Thank you for working with Advantage Dental.

_____leaving the area
_____Office Hours
_____Insurance Changed
_____Changing dentist because of office convenience
_____Patient satisfaction issue(s)

Office Use Only:
X-Rays Duplication Complete _____Yes _____No Date:__________
X-Rays Mailed/Emailed _____Yes _____No Date:__________
Patient Picked Up _____Yes _____No Date:______________

ADVANTAGE DENTAL
560 Celebrate Virginia Pkwy, Suite 107,
Fredericksburg, Virginia 22406
Office (540) 286.1110
Fax (540) 286.3783
www.advantagedentalva.com
office@advantagedentalva.com