Release of Records Request

Release of Records Request

Would like us to obtain your records from a previous office? Fill out the information below.

Office Name

Office Phone Number (___) ___-____

Fax Number (___) ___-____

Email

Address

City

State Please sele...

Zip Code

I hereby authorize and request the release of my dental records, treatment records, x-rays, periodontal charting, or copies of such and request that they are transferred to:

Hansen Family Dental
6615 W. Argent Rd
Pasco, WA 99301
(509)547-9951 Fax (509)547-3008
(office@hansenfamilydental.com)

Patients First Name *

Patients Last Name *

Date of Birth * mm/dd/yyyy

Signature of Patient or Legal Guardian *

Today's Date 03/28/2024

Relationship to Patient