Records Release Request

Date: _____

Patient Name: _____

Date of Birth: _____

I authorize Plum Grove Dental Associates to release information including dental records and/or radiographs for treatment rendered.

I have instructed Plum Grove Dental Associates to...

- ☐ Email
- ☐ Mail
- ☐ Fax
- ☐ Prepare for Pick-Up

the medical records as indicated above.

Name / Address: _____

_____

_____

Fax Number: _____

Signature: _____