Sewee
Dental Care

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PATIENT RECORDS REQUEST FORM

Name of patient whose record is requested: _____

DOB _____ Phone _____

Address _____ City/State/Zip _____

Please provide a copy of the record as indicated below:

- ❑ The full health record maintained by this provider/practice
- ❑ The health record for the following time frame: _____ through _____
- ❑ A specific section of the health record as described below:

  _____

  _____

Release to: _____

Signature of patient _____

Signature of authorized representative _____

Relationship to patient _____

Date _____