Ayham Yacoub, DMD
2123 N. 1ST Avenue, Suite A2
Whitehall, PA 18052
P: (610) 266-1101 F: (610) 266-1170

DENTAL RECORD RELEASE FORM

I, ______________________________ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Name of Patient: ______________________________ Date of Birth: ____________

Name of Patient: ______________________________ Date of Birth: ____________

Name of Patient: ______________________________ Date of Birth: ____________

Records being requested:

( ) Current radiographs	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Record	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos

() Other: ____

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Signature of Parent/Guardian: ______________________________ Date: ____________