TUMWATER
FAMILY DENTISTRY

# REQUEST FOR RELEASE OF DENTAL RECORDS

I, _____ hereby request that Dr. _____ release the following dental records to:

RICHARD C. DOWNING, DDS
6939 Littlerock Road SW, Suite B
Tumwater, WA 98512
(360) 352-0401
office@tumwaterfamilydentistry.com

Patient is scheduled in our office on _____.

Please release the following records for each person identified below prior to the above date:

_____ Patient chart notes, regarding: _____

_____ X-rays, periodontal chart, and dates of last cleaning

****If patient is a periodontal patient, please provide the most current date of SRP'S**

**UR:** _____ **LR:** _____ **UL:** _____ **LL:** _____

I am over the age of 18 and am requesting the release of dental records for:

_____ Self (Each person over 18 must complete this form) DOB: _____

_____ (a minor child) DOB: _____
Name

_____ (a minor child) DOB: _____
Name

_____ (a minor child) DOB: _____
Name

_____ _____ _____
Signature Printed Name Date Signed