Foothills Dental Care
2205 Channing Way
Idaho Falls, ID 83404-8016
(208)529-4484

PATIENT RECORD RELEASE FORM

Name of Patient whose Dental Record is Requested: _____

DOB: _____PHONE:_____

ADDRESS:_____CITY/STATE/ZIP_____

PLEASE PROVIDE A COPY OF THE DENTAL RECORD AS INDICATED BELOW:

____Perio charting
____Bitewing X-rays (If less than 1 year old)
____Pano X-ray (If less than 3 years old)
____Other:_____

PLEASE FORWARD MY REQUESTED DENTAL INFORMATION TO:

Name of new Dentist: _____

Address of Dentist: _____

City, State, Zip: _____

Office Phone: _____

Office Email *required for X-rays: _____

I understand that my express consent is required to release any healthcare information relating to my dental care. I hereby consent to the release of the above requested information only.

_____
Signature of patient or the patients authorized representative Date Signed

_____
Relationship or status if signed by anyone other than patient (parent, legal guardian, etc.)