Patient Records Request Form

Family Dental Care
221 6th Ave Se Suite 5
Aberdeen, SD 57401
Phone: 605-226-1867 Fax: 605-226-3993

PATIENT INFORMATION	Patient Name Address City State Zip Date of Birth Phone Number
RELEASE INFORMATION TO	Company. Person, Facility Address City State Zip Phone Number
PURPOSE OF RELEASE	☐ Attorney Request ☐ Transfer Care ☐ 2nd Opinion ☐ Self
ADDITIONAL FAMILY MEMBERS	Name Date of Birth Name Date of Birth Name Date of Birth Name Date of Birth

All future appointments will be cancelled upon signing form for transferred care.
I understand that my signature is authorizing Family Dental Care to release my records to the said office, company or person. These records can not be future disclosed without the permit of the patient.

Signature of Patient Date

Signature of Legal Representative Relationship to Patient