Riverwest Dental
1655 Pancheri Drive
Idaho Falls, ID 83402-3169
(208)522-1911

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.)