VADHI OHIO FAMILY DENTAL
6023 E. MAIN STREET
COLUMBUS, OH 43213
614-864-6000

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:_____

_____

Signature of Parent/Guardian:_____ Date:_____