MICHAEL H. CHOW, D.D.S., P.A.

Specialist in Pediatric Dentistry and Orthodontics

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REQUEST FOR RELEASE OF RECORDS

I, _____, hereby request and give my permission to Dr. Chow to provide the office of:

Dentist Name: _____

Address: _____

_____

_____

Email: _____

with any and all information requested with respect to the dental/orthodontic care of myself/ my child, _____ (Date of Birth _____). Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records or medical records.

I agree to pay the cost of duplicating any records, if necessary. A photograph or fax of this release will be as effective and valid as the original.

Records released to:

Signed: _____ Relationship to Patient: _____
(Patient or Parent/Legal Guardian)

Print Name: _____ Date: _____

Address: _____

_____

Reason for transfer:

____ New dentist is closer to patient
____ New dentist accepts patient's insurance and Dr. Chow does not
____ New dentist has more convenient hours
____ Patient/Parent or Guardian is not happy with Dr. Chow's services
____ Other _____