Information Release Request

UNIVERSITY OF THE PACIFIC
Arthur A. Dugoni School of Dentistry

Patient Name: _____ Patient DOB: _____

Patient Account #: _____ Date of Request: _____

I, _____ request and authorize University of the Pacific, Arthur A. Dugoni, School of Dentistry to duplicate and release my dental records.

☐ I want my records and x-rays ☐ I want my x-rays **only**

Please choose the format in which you would like your record sent:

☐ CD

Mailing address: _____

_____

☐ Email - Please be advised that communications via email are not secure

Email Address: _____

☐ This is a request to have my records sent to a third party (i.e. New Dental Provider)

Name: _____

Please note: A fee may be charged for repeat requests.

Please allow 7-10 business days for processing. If you have questions or desire information not usually included in a general records release please contact a member of staff.

_____

Patient Signature or Parent/Guardian Signature

For Office Use Only
Date Sent: _____
Sent By: _____
Notes: _____