



**COLUMBIA
DENTAL**

Corporate Office:
483 Middle Turnpike West
Suite 309
Manchester, CT 06040

860-645-0111

Patient Record Release Request Form

Patient Name: _____

Address: _____

Office: 483 Middle Tpke W Manchester, CT (Main) Parkade – Manchester Center Street – Manchester

- Bristol Enfield Hartford New Britain
- New Haven New London New Milford Norwalk
- Rocky Hill Torrington Waterbury

TO WHOM IT MAY CONCERN

I authorize the release of dental records and radiographs (x-rays) relevant to dental treatment or copies of such and I understand that I will be responsible for my records.

DATE: _____

PATIENT: _____

DATE OF BIRTH: _____

ACCOUNT ID: _____

Date of Last Exam: _____ Date of Last Prophy: _____

Date of Last Full Mouth X-Rays (FMX): _____ Date of Last Bite Wings (BW): _____

Please contact our office if we can be of further assistance. If requesting unencrypted email you must understand that it is possible that email could be intercepted.

Signature of Patient (Parent if minor): _____ Date: _____

-----For Office Use-----

- Approved for Release Disapproved for Release (Reason to follow)

Date of Release: _____ Initials of Person Releasing Information: _____

Method of Release: Copies handed directly to patient Email Mail CD Flash Drive

Scan this into patient document Center