If you have been to another dentist within the past five years, you can request that a copy of your records (including xrays) be sent to us. This can assist us in diagnosing and may prevent the need for new xrays – saving you both in cost and unnecessary exposure to radiation.

Please fill in the name of your most recent dentist/dental office below, and we will forward the request to them.

Release of Records Authorization

I hereby request and give authorization to Dr. _____

_____
Address

_____
City, State Zip

_____
Phone

_____
Fax

to provide copies of **ALL of my records** (including ALL x-rays) to:

Rockside Family Dental Care
6132 West Creek Road
Independence, OH 44131
(216)524-8481
info@rocksidedental.com

_____	_____	_____
Signature (Parent, Legal Guardian or Custodian of patient if patient is a minor)	Printed Name	Date

If you would prefer that we not contact your previous provider, or if you do not have recent records, please initial on the next line and sign & date at the bottom.

_____ I do not want my previous dentist/dental office to be contacted for records.
initials

_____ I do not have xrays/records within the past five years.
Initials

_____	_____	_____
Signature (Parent, Legal Guardian or Custodian of patient if patient is a minor)	Printed Name	Date