PATIENT RECORDS REQUEST FORM

Name of Patient Requesting Records_____

Date of Birth_____ Phone_____

Address_____ City/State/Zip_____

Name and address of practice sending records _____

_____

Please send:

The full health record (and x-rays) maintained by provider/practice _____

The health record for the following time frame: _____through_____

A specific section of health records as described below:

_____

_____

_____

Signature of Patient_____

Name of Patient (please print) _____

Relationship to Patient (if other than patient) _____

Date_____

Please send to:

Tappan Dental

165 Washington St
Tappan, NY 10983
845-359-7654
info@tappandental.com