DENTAL RECORDS RELEASE REQUEST

I, _____, give permission to release copies of my dental records from the following office:

Dentist Name: _____ Phone Number: _____

Fax or Email: _____

Please forward the following information:

- Entire Dental Record for only myself
- Entire Dental Record for all my family members
- Current Treatment Plan
- Copies of Dental X-rays
- Other_____

I understand that a copy of my records will be forwarded to the address below and that the original record remains the property of the dental office and will be maintained by State Dental Laws.

Name of Patient: _____

Family Members to be included: _____

Signature of Patient/Parent or Guardian_____

Dr. Robert A. Bartusiak, DMD

2000 Waterdam Plaza Dr. Ste. 280, McMurray PA 15317

Phone Number: 724-941-3090 – Fax: 724-941-3018

Email: drrbartusiak@verizon.net