Arlington Dental Solutions

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Dental Records Release Form

I, _____ hereby authorize the doctor and staff of Arlington
(please print patient or guardian name)

Dental Solutions to release of records concerning my dental health to:

☐ Me (Patient)
Address: _____
_____
Phone #: _____

☐ Dentist/Dental Office
Address: _____
_____
Phone #: _____

☐ Parent/Guardian
Address: _____
_____
Phone #: _____

I am requesting that you release the following:

☐ All x-rays _____

☐ All treatment notes _____

Reason for Release:

☐ Second opinion
☐ Moving
☐ Insurance change
☐ Not happy with practice

Release of the records is limited to the new dentist or the patient; records will not be released to other individuals (unless the patient is a minor child).

_____ _____
Patient's Signature Date