CHELMSFORD DENTAL GROUP - RECORD DUPLICATION FORM

275 Billerica Road, Chelmsford, MA 01824 T: 978 667 6600

PATIENT
NAME____

ADDRESS____

PHONE #____

I authorize the release of my records to: _____________Myself _____________Someone Else

Please provide the email where you want the records sent_______________________________________

Please provide mailing address if you want the records emailed___________________________________

PLEASE MARK THE REASON FOR REQUEST:

______Quality of Work ______Service of Staff ______Billing Issues

______Insurance Change ______Can’t Get Appointment Time I Need ______Moved

______Other

Please complete this form and email/fax/mail the signed copy to the above address. Please allow at least 10 business days for processing your request. We cannot take responsibility for the privacy of dental records which are sent over the internet. If you want us to mail your records to you, we will mail them to the address on file. Thank you.

____
Patient / Guardian Signature (Relationship to Patient)

____
Date