RECORD RELEASE FORM

Jill Kollar DMD Professional LLC | d/b/a Precision Dental of Windsor

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Complete ONE section below. Section A asks another provider to send your records to us. Section B authorizes us to send your records to another provider or person.

Section A: Send my records TO Precision Dental of Windsor

I request that my dental records relevant to dental treatment, or copies of them, be released by:

Provider or practice name: _____

Address: _____ Phone: _____ Fax: _____

Section B: Precision Dental of Windsor may SEND my records

I authorize Precision Dental of Windsor to release my dental records relevant to dental treatment, or copies of them, to:

Name: _____

Address: _____ Phone: _____ Fax or email: _____

Patient information

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Records requested

( ) Current Radiographs ( ) Dental Health Status ( ) Treatment Record

( ) Charts ( ) Health History ( ) Prescription Records

( ) Photos ( ) Clinical Notes

( ) Other: _____

Purpose of this release: continuity of care, or: _____

This authorization is valid for 12 months from the date signed, unless an earlier date is written here: _____. I may revoke it in writing at any time, except for records already released in reliance on it.

Signature of Patient or Personal Representative: _____ Date: _____

Print Name: _____

If you are signing for the patient, your relationship to the patient: _____