MILL POINT DENTAL CENTER
Michael Longlet, DDS Chelsea Longlet, DDS

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Attention: _____ FAX: _____

RECORDS RELEASE

For following patient

NAME: _____

DOB: _____

Has requested their records and films be sent to our office at the e-address listed above.

This information is strictly confidential and will not be released without the written consent of the patient or guardian, in accordance with HIPAA regulations.

Please release these records at your earliest convenience. The patient will be seen on the following date:

_____

Thank you,

Mill Point Dental Center

Patient or Guardian Signature: _____

Date:_____/_____/_____