PATIENT RECORDS REQUEST FORM

Minnehaha Dental

3208 NE 54TH ST
VANCOUVER WA 98663
PHONE (360) 693-8181 FAX (360) 750-9069

Name of Patient Whose Records Is Requested _____

DOB _____ Phone
_____

Address _____ City/State/Zip _____

Please provide a copy of the records as indicated below:

____ The full health record maintained by this provider/practice

____ The health record for the following time frame: _____ through _____

____ A specific section of the health record as described below.

_____

_____

____ A summary of the information requested above is adequate to fulfill this request.

____ I request my records be released to/from

_____

_____

_____

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____

EMAIL: **info@minnehahadentalcare.com**