Deluxe Dental Group

Clinical Record & Radiograph Release Request

By signing this form, I _____ authorize you to release my confidential health information. By releasing a copy of my dental records, summary or narrative of my protected health information to person(s) or entity listed below:

Release To:	**Release From:**
Deluxe Dental Group	Office Name: _____
1353 N Meridian Rd. 101	Address: _____
Kuna, Idaho 83634	_____
Phone (208) 922-1755	Phone: _____
Info@deluxedentalgroup.com	

I request the following:

____ Bitewing x-rays taken within the last 2 years

____ FMX or Pano taken within the last 3-5 years

____ Periapical within the last 12 months

____ Perio Charting

Patient(s) Name:	_____	**Date of Birth** _____
	_____	**Date of Birth** _____
	_____	**Date of Birth** _____
	_____	**Date of Birth**_____
	_____	**Date of Birth**_____

Patient/Guardian Signature: _____

Date: _____