Johnson Family Dentistry

8240 Naab Road, Suite 365

Indianapolis, Indiana 46260

Phone: (317)372-3282

Fax: (317) 879-8085

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby request that you release the following patient's records:

Patient's name:

Address:

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

_____________________________________ _____________________

(Signature) (Date)

New Practice Name & Address: