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RECORD RELEASE FORM

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PATIENT

I hereby request and authorize James S. Trichak, D.D.S. to disclose and provide copies of mine or my child's dental records to:

_____
Name

_____
Address

_____
City State Zip

_____
Telephone number Fax number

These records may include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatments, treatment and financial records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release James S. Trichak, D.D.S. from any and all liability arising from compliance with my request and disclosure of the requested information. I understand that the usual duplication fee is $25.00.

- ☐ My child will be returning to Dr. Trichak's practice.
- ☐ My child will not be returning to Dr. Trichak's practice.
- ☐ I am obtaining a second opinion for my child and will notify you at a later date if I wish to schedule my treatment for my child.

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SIGNATURE OF PATIENT/PARENT OR GUARDIAN DATE