JAMES S. TRICHAK DENTISTRY
16841 N. 31st AVE., Suite 140
PHOENIX, AZ 85053
(602) 938-4373 FAX (602) 843-3911

ADULT RECORD RELEASE FORM

I _____, hereby request and authorize James S. Trichak, D.D.S. to disclose and provide copies of my dental records to:

_____
Name

_____
Street Address

_____
City State Zip

_____
Telephone number Fax number

_____
Email

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 the usual duplication fee is $25.00.

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

_____
PATIENT'S SIGNATURE DATE

REVISED 2012