GRAND.DENTAL

Request for patient information

Dear _____,

We share a mutual patient, _____,

date of birth _____, who has an upcoming appointment at our office. We would appreciate your help in acquiring this patient's current pantomograph and bitewing radiographs. While our office would prefer digital images, we can receive them by whatever medium and mode is most suitable to your office.

Address	**Email**	**Fax**
1005 Grand Avenue Suite 200 West Des Moines, IA 50265	ContactUs@Grand.Dental	515-223-1062

Patient release

I confirm that I am the individual listed below and have the legal authority to initiate a transfer of records containing protected health information for the individual listed above. I authorize the aforementioned provider to release the requested protected health information and send it Grand Dental in a manner consistent with the Health Insurance Portability & Accountability Act of 2006.

_____

Printed name

_____ _____

Signature Date

Relationship: ☐ Self ☐ Parent or legal guardian ☐ Medical power of attorney