GRAND.DENTAL

Update October 21, 2017

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 most recent pantomograph and bitewing radiographs. While our office would prefer digital images, we can receive them by whatever medium and mode is best suited by 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 to Grand Dental from another provider. I authorize the aforementioned provider to release the requested protected health information and send it Grand Dental.

_____
Printed name

_____ _____
Signature Date

Relationship: ☐ Self ☐ Parent or legal guardian