Chandler Dental Health

chandlerdentalhealth.com help@cdhsmiles.com
1035 W. Queen Creek Rd. | Suite 206 • Chandler, AZ 85248 (480)899-6677

Records Release Form

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ * ____________ * ____ ____________
Last First MI Preferred Name

Title: ________ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* ________ **Prev. Visit:** ________ **Email Address:**
____

Phone: ________ * ________ ________ ____ **Best time to call:** ________
Home Mobile Work Ext

Address: ____________ * ____________
Address 1 Address 2

____________ * ____ * ____-____ *
City State Zip Code

I hereby request Chandler Dental Health release my records to:
◯ Myself ◯ My new dentist ◯ Other

Contact information

____
____
____

◯ I am requesting my records be sent to: Chandler Dental Health

Please include xrays, treatment plans and history of visits. Please send xrays as individual images and use .DEX format when available

Signature ____________________ **Date** ________

Response Date: ________