Michael H. Chow, D.D.S., M.M.Sc.

Specialist in Pediatric Dentistry and Orthodontics

49 Lawrence Street Methuen, MA 01844

Phone: (978) 689-9777

Request for Release of Records

I, _____, hereby request and give my permission to Dr. Chow to provide the office of:

Dentist Name: _____

Address: _____

_____

Email: _____

with any and all information requested with respect to the dental/orthodontic care of myself/ my child, _____ (Date of Birth _____). Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental or medical records.

I agree to pay the cost of duplicating any records, if necessary. A photograph or fax of this release will be as effective and valid as the original.

Records released to:

Signed: _____ Relationship to Patient:_____

(Patient or Parent/Legal Guardian)

Print Name: _____ Date: _____

Address: _____

_____

Reason for transfer:

____ New dentist is closer to patient

____ New dentist accepts patients' insurance and Dr. Chow does not

____ New dentist has more convenient hours

____ Patient/ Parent or Guardian is not happy with Dr. Chow's services

____ Other_____