



OAKLAND DENTAL CARE
2510 S. ROCHESTER RD
ROCHESTER HILLS, MI 48307
248-852-6400

RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Name of Patient _____ Date of Birth _____

Records being requested:

- Current radiographs Dental Health Status Reports
- Diagnostic Casts Treatment Records Charts
- Health History Prescription Records Photos

Other: _____

Signature of Parent/ Guardian _____ Date _____