Request for Dental Records

Patient Information:

Name: ____ Date of Birth: __________________

Address: ________________________________Phone: __________________

Records Requested:

Reason for Request (if insurance please specify new type): _______________________________

(Request will be valid for 90 days and may be revoked any time prior to the expiration date)

Records to be sent to:

Encrypted email: ____________________________@_________________________________

Patient(18 or over)/Guardian - Signature: ___________________________Date: ____________

If guardian relationship to patient: ____________________________________

Please send your requests to the office email listed below.

Please contact us if you have any questions about your request.

Needham patients - Dentists@Chestnutdental.com – tel. 781-444-6650

Franklin patients – chartsfranklin@chestnutdental.com – tel. 508-520-6660

Bedford patients – chartsbedford@chestnutdental.com – tel. 339-234-5076

For office use only

Records sent by – Name (CDA Staff): __________________________________Date: ____________