**PHILLIPPI AND KWON**
FAMILY DENTISTRY

## *PATIENT RECORD RELEASE FORM*

I hereby authorize and request Dr. P. Jeffrey Phillippi, DDS, PA and/or Dr. David H. Kwon, DDS, PA to disclose and give copies by mail or Email to:

_____
(Dentist Name)

any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following: dental records including operative records, diagnosis, dental history, findings and procedure, treatment and interviews, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above names person or institutions, I hereby release them from any and all liability arising from such disclosure.

Please forward this information to the following address and/or email address:

Address of Dentist: _____

_____

City, State & Zip: _____

Phone: _____

Email Address: _____

Please list all patient(s) of records needed to be sent:

1. _____ DOB: _____
2. _____ DOB: _____
3. _____ DOB: _____
4. _____ DOB: _____
5. _____ DOB: _____

Signature: _____ Date: _____

Reason for Leaving our practice: _____

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