Request For Release Of Records

Please release all requested records to the Center For Dental Medicine.

Date of request: ____________________________

Patient Name: ____ Patient Date of Birth: ________________

Patient, parent, or guardian signature: ____

Brief Description of Chief Complaint: ____

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For Physicians: Please send a report of your records pertaining to the chief complaint listed above.

Primary Care Physician: ____

Address: ____

Phone: ____ Fax: _______________________________________

Specialty physician: ____ Specialty: ____________________

Address: ____

Phone: ____ Fax: _______________________________________

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For Dentists: Please send copies of **all** diagnosis and treatment records. Please include your earliest radiographs, as well as the most recent radiographs taken. We are reconstructing the entire history for this patient, and need old as well as recent radiograhs and records. We find that complete records are vital in creating a treatment plan that is the most appropriate for each patient.
We prefer to receive images by email to office@wartell.com.
If you make prints from digital images, please print them on high resolution or photo paper, at the highest quality print setting.

If you charge for making copies of records and radiographs (we do not), the Center For Dental Medicine guarantees payment of your charge.

Primary Care Dentist: ____

Address: ____

Phone: ____ Fax: _______________________________________

Specialty Dentist: ____ Specialty: ____________________

Address: ____

Phone: ____ Fax: _______________________________________

Send records to:

Center For Dental Medicine
2019 Galisteo St, Bldg J2
Santa Fe, NM 87505
phone: 505-474-4644 • fax: 877-748-9620 • email: office@wartell.com

Thank you very much for your help in continuing care for our patient.

Sincerely,

Pat Wartell, Patient Care Coordinator