Request for Dental Records

Patient's Name: ______________________ Date of Birth: ______________

I hereby request and give authorization to:

Dr. ____

____
Address

____
City, State, Zip

____
Telephone

Please mail a copy of all my records, including radiographs, to:

Stanley A. Altizer D.D.S.
7500 Town Centre Drive, Suite 100
Broadview Heights, OH 44147

OR

Send by secure E-Mail to: info@draltizer.com

Patient Signature:____Date:____________

If the request is by a patient's personal representative:

Print the Name of the Personal Representative:_______________________________________

Relationship to the Patient:____

I certify that I have the legal authority under federal & state laws to make this request on behalf of the patient identified above.

Signature of Personal Representative:______________________________Date:_____________