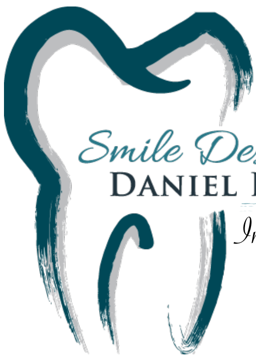

Smile Designs by
DANIEL H. DAVIS DDS, PA
Implant, Cosmetic & Restorative Family Dentistry

4000 Brown Trail, Colleyville, TX 76034
danielhdavisdds@sbcglobal.net
817.656.9366

Request for Patient Records

Patient Name:________________________________ **Date of Birth:**______________________

Please check the types of records you wish to access/have transferred:

- ☐ Most recent bitewing X-rays
- ☐ Most recent FMX/pano
- ☐ Most recent periodontal charting
- ☐ Other (please specify)________________
  ____

Please check all that apply:

- ☐ I wish to review the requested records in person.
- ☐ I wish to pick up a copy of the requested records in person.
- ☐ I wish to have my records emailed to:

____
Name of Person or Doctor's Office

____
Email Address

- ☐ I wish to have the copy of the requested records mailed to:

____
Name of Person or Doctor's Office

____
street address

____
City State Zip

If the request is by the patient:

____ ________________
Patient Signature Date

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

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

____ ________________
Name of Personal Representative Relationship to Patient

____ ________________
Signature of Personal Representative Date

For questions pertaining to access to patient records, or if you would like to request records in a format not listed above, please contact the Privacy Official, Cathy Davis, at (817) 656-9366.

For dental office use only:

- ☐ Request for access denied (attach written denial).
- ☐ Request for access approved

If approved, please note the date and manner in which the request was fulfilled below: