DENTISTRY
at Golden Ridge

Records Release Form

Today's Date: _____

I, _____ , request that my dental records be released

☐ **To**
☐ **From**

Office Name:

_____

Office Address:

_____

Office Phone: **Office Email:**

_____ _____

_____ _____

☐ **To**
☐ **From** **Dentistry at Golden Ridge**

How do you want to deliver your records? (mark with X)

_____ I will be picking up/receiving my own records from the above noted office

_____ I request that my records be sent/emailed to the following office:

☐ **Dentistry at Golden Ridge**
755 Heritage Road, Suite 120
Golden, CO 80401
Phone: 303.395.3333
Email: office@dentistrygoldenridge.com

☐ **Office noted above**

According to Colorado State Law 25-1-801(b)(c) "A copy of such records, including x-rays, shall be available to the patients or his or her designated representative, upon written authorization - request a copy of such records, dated and signed by the patient upon reasonable notice and payment of reasonable costs. For purpose of this section, patients' records does not include a doctor's office notes."

Print Patient's (or Parent's or Legal Guardian's) Name **Date**

_____ _____

Signature of Patient (or Parentor Legal Guardian)

_____