SofTouch DENTAL
Center For Aesthetic Dentistry

RECORD RELEASE FORM

I give permission to SofTouch Dental and the Staffs to release my dental records for:

Patient's Name: _____

The following record will be sent/ released:
X-rays: _____ Chart Records: _____

I request the dental records to be sent/released to:
Self: _____ Dentist: _____

Address: _____

City: _____

State/ Zip: _____

Phone: _____

Fax: _____

Dental Office's Secured Email: _____

I understand that the office has **30 days** to forward my record and I can pick up my record as soon as the office notifies me that the record is ready.
I understand that there is a **$1.00** charge for each copy/page of record and a **$2.00** charge for X-rays/page of record.

Signature of Patient/Guardian: _____

Date: _____

3232 W. Lake Mary Blvd. #1400. Lake Mary, FL. 32746
Office: (407) 323-1010 **Fax: (407) 323-1021** **Text: (407) 808-9108** www.softouch-dental.com