# REQUEST FOR RECORD(S) RELEASE CONSENT

Privacy Official: Chris Fagan, DDS, PLLC
423 N. Van Buren | Enid, OK 73703 | (580) 233-0043

Parent/Guardian's Name: _____ Phone Number: _____

Patient(s) Name: _____ Date of Birth: _____

_____ _____

_____ _____

Please describe the records you wish to access and the approximate dates of the records: _____

_____

☐ I wish to **SEE** the requested records

☐ I wish to get a **COPY** of the requested records

☐ I would like a copy to be emailed to the following email: _____ @ _____

***We do not recommend sending patient information in an unencrypted email because third parties may be able to access your records.***

☐ I would like a copy to be sent to the following location:

To the Attention of: _____

Address: _____

City: _____ State: _____ Zip: _____

**FEES**

Our practice may charge a reasonable, cost-based fee for copies of patient information, and for postage to mail records, if requested.

**QUESTIONS**

Please contact our privacy official listed at the top of this page if you have any questions about your request to inspect or duplicate records.

**If the request is by the patient:**

Patient Signature: _____ Date: _____

**If the request is by a patient's personal representative (Parent or Guardian):**

Print Name of Personal Representative: _____ Relationship: _____

*I CERTIFY THAT I HAVE LEGAL AUTHORITY UNDER FEDERAL AND STATE LAWS TO MAKE THIS REQUEST ON BEHALF OF THE PATIENT IDENTIFIED ABOVE.*

Signature of Personal Representative: _____ Date: _____

Se habla español For language assistance services, free of charge, please visit www.freetranslation.com.

---

**FOR BRUSH PEDIATRIC & FAMILY DENTISTRY USE ONLY**

☐ Request for access is DENIED (attach written denial)

☐ Request for access is APPROVED. Privacy Official's Signature: _____