



Akoya Pediatric Dentistry
15761 Sheridan St, Suite A, Southwest Ranches, FL 33331
(954) 799-6212

Release of Medical Records Form

DATE

MM/DD/YYYY

PATIENT FIRST NAME

PATIENT LAST NAME

REQUESTED BY:

RELATIONSHIP TO THE PATIENT:

PLEASE SPECIFY RECORDS/RADIOGRAPHS THAT ARE BEING REQUESTED:

I,

Name

authorize Akoya Pediatric Dentistry to release the radiographs/medical records requested above.

RECORDS TO BE FAXED/EMAILED TO:

PRINT NAME:

SIGNATURE

Clear

DATE



FOR OFFICE USE ONLY

PATIENT NAME:

- ☐ Clinical notes/radiographs reviewed by doctor
- ☐ Account reviewed and patient has \$0 balance

If patient is no longer returning to the practice

- ☐ Inactivate account & clear continuing care
- ☐ All future appointments deleted

REASON FOR PATIENT REQUESTING RECORDS/RADIOGRAPHS OR LEAVING OUR PRACTICE: