Kendall Square Dental Associates
Health Information Request Form

Patient Name: Date:

Telephone: Fax:

Address:

Please check off appropriate request below:

____ Request for duplication of all dental record.

____ Request to inspect dental record.

____ Request for amendment of dental record.

____ Request for confidential communication.

Note:

Address to mail records to:

Patient Signature **Date**

Parent or Legal Guardian Signature **Date**