Dental Records Release Request

Date: _____

To:_____
Address:_____
_____
_____

Office Phone Number: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request they be transferred to:

Signature Dental Experience
Dr. Vijeyta Bhatia
109 N. Williamsburg Drive
Bloomington, IL 61704
309-662-3123

If you have digital x-rays and or patient information, please email them to bloomingtondentist@yahoo.com

Thank you,

Signature: _____

Print Name(s) and DOB_____

_____

_____

Relationship to Patient: _____

Vijeyta Bhatia, D.D.S., P.C.
109 North Williamsburg Drive • Bloomington, Illinois 61704 • 309-662-3123 • Fax: 309-661-0798
E-mail: bloomingtondentist@yahoo.com
www.SignatureDentalExperience.com