Always Welcoming New Patients!

WALTHAM FAMILY DENTAL – RECORD DUPLICATION FORM

30 Grant St., Waltham, MA 02453 T: 781 894 1634 Fax: 781 894 6226 Email: office@walthamfamilydental.com

Name:_____

Address:_____

Phone Number:_____

I authorize the release of my records to: ____Myself _____Someone Else

Please Provide the email where you want records sent_ _____

Please provide mailing address if you want records mailed_____

PLEASE MARK THE REASON FOR RECORD REQUEST:

_____Quality of Work _____Service of Staff _____Billing Issues

_____Insurance Change _____Can't Get Appointment Time I need _____Moved

_____Other

Please complete this form and email/fax/mail the signed copy to the above address. Please allow at least 10 business days for processing your request. We cannot take responsibility for private dental records which are sent over the internet. If you want us to mail your records to you, we will mail them to the record on file. Thank you.

_____

Patient / Guardian Signature (Relationship to Patient)

_____

Date