



222 N. Plum Grove Rd.  
Palatine, IL 60067-5233

## Records Release Request

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize **Plum Grove Dental Associates** to release information including dental records and/or radiographs for treatment rendered.

I have instructed Plum Grove Dental Associates to...

- Mail
- Fax
- Prepare for Pick-Up

the medical records as indicated above.

Name / Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_