UNIVERSITY OF
NEW ENGLAND
Oral Health Center

Patient Request for Release of Dental Records

Date: ____________________________

Record Number: _________________

I, (patient or guardian name) ____authorize University of New England-Oral Health Center to copy and release to me or the following individual, ____a copy of my records.

Are you returning to UNE Oral Health Center? Yes___ NO ____

Select one format:

Radiograph copies (x-rays)

- X-ray images copied onto unencrypted USB Flash Drive
- X-ray images sent electronically via secure email to:

____

Email Address

Phone # for verification: _________________________________

Patient record copy

- Paper copy of patient medical/dental history including treatment notes

Printed Name (patient or guardian name) ____

Patient Mailing Address:____

Patient Date of Birth __/___/____ Patient Telephone Number _______________________

Signature: ____

Patient or Legally Authorized Representative

Mail- Return completed form to:
University of New England
Oral Health Center
1 College St.
Portland, ME 04103
Ph. 207-221-4747

FAX: To fax your release form fax to **207-221-4805 or 207-221-4799**

Please allow up to 1 week for request to be completed.