UNE UNIVERSITY OF NEW ENGLAND
Oral Health Center

Patient Request for Release of Dental Records

The fee for release of records is $15. Payment may be made with cash, check, debit card, Visa, Master Card. Upon receipt of the completed form and payment, record release may take up to 21 days.

Date:_____ _____ Record Number:_____

Individual/practice to whom records are to be released, if not yourself:

Name:_____

Address:_____

Phone Number:_____

Do you plan to return to UNE Oral Health Center for continued care? ☐ Yes ☐ No

Select the format for release of your records (select one):

☐ Treatment notes only- paper copy to be sent by USPS mail
☐ X-rays and treatment notes to be copied onto unencrypted USB flash drive and sent by USPS mail
☐ X-rays and treatment notes to be sent electronically via encrypted email to:

_____
Email Address

Phone # for verification: _____

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.

Printed Name (patient or guardian name) _____

Patient Mailing Address: _____

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

Signature: _____

Patient or Legally Authorized Representative

Send completed form and payment to: University of New England Oral Health Center
1 College St.
Portland, ME 04103

Or fax completed form to: 207-221-4805 or 207-221-4799
Credit card payments may be made by phone: 207-221-4747