

**MEDICAL RECORDS RELEASE**

**TO ANOTHER PRACTICTIONER:**

I would like all of my dental records including current x-rays copied and sent to the office of:

**. .**

**. .**

**. .**

I understand that in the event that original records and/or x-rays must be sent they are no longer the responsibility of Hubbard Dental Care once they leave to possession of the practice.

**PATIENT NAME: .**

**PATIENT/PARENT/GUARDIAN SIGNATURE: . DATE: .**

**TO MYSELF:**

I would like all of my dental records including current x-rays released to myself. I understand that in the event that I receive original records and/or x-rays they are no longer the responsibility of Hubbard Dental Care once they leave possession of the practice.

**PATIENT NAME: .**

**PATIENT/PARENT/GUARDIAN SIGNATURE: . DATE: .**

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