Paul C. Johnson, DDS
8240 Naab Road Suite 365
Indianapolis, Indiana 46260
(317) 872-3282
Fax: (317) 879-8085

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to requests the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby request that you release the following patient's records:

Patient's name:

Address:

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

_____ _____
(Signature) (Date)

New Practice Name & Address: