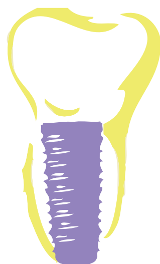

Babak Noohi, DDS, MS

REQUEST FOR DENTAL RECORDS

Date of Request: ___________________________

Request made to Office of Dr: ____

Dr. Office Address: ____

Dr. Office Telephone: ___________________________ Office Fax: ________________________

________________	____________	___	________________
Patient Last Name	First Name	MI	Date of Birth

____
Street Address

____
City State Zip Code

________________	____________________	________________
Home Telephone	Office Telephone (or Mobile)	Fax Number

SPECIFIC DESCRIPTION OF INFORMATION REQUESTED

☐ Dental Records (preferably in electronic format, PDF or Word document, sent via email; otherwise hardcopy)

☐ X-rays (preferably JPG, TIF, PDF electronic format sent via email; otherwise hardcopy)

Please do not send electronic records that can only be accessed through your software.

REQUESTED DATES: From _________________________ To ___________________________

RELEASE INFORMATION TO:

Babak Noohi, DDS, MS
499 South Capitol Street SW, Suite 109,
Washington, DC 20003
Telephone: (202) 484-5686 / Fax: (202) 484-8617
Email: officemanager@thecapitolhilldentistry.com

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law. I understand that I have a right to revoke this authorization at anytime and that my revocation must be submitted in writing to the office where I received treatment. I understand that my revocation is not effective to the extent that the persons or organization in which I have authorized to use and/or disclosure of my dental history have acted in reliance upon this authorization.

This authorization will expire on (specify date): _____________________

______________________________	______________________________
Print Name of Patient	Print Name of Guardian/Authorized Representative
______________________________	______________________________
Patient Signature	Signature of Guardian/Authorized Representative
______________________________	______________________________
Name of staff person processing request	Relationship to Patient