

Fine Dentistry of Downtown Orlando P.A.
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REQUEST OF DENTAL / MEDICAL RECORDS TO BE RELEASED

Date: _____

To: Fine Dentistry of Downtown Orlando P.A

I hereby authorize and request you to release my records to:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Patient Records to be Released: _____

_____ Please call me when records are ready and I will pick them up

_____ Please mail to the above address

Reason for records release: _____

Patient Name or Legal Guardian

Date

Signature