

COASTAL IMAGE DENTAL

RELEASE OF MEDICAL RECORDS

I hereby request that my medical records be released to:

_____ **Myself**

Name: _____

Address: _____

Phone: _____ Fax: _____

_____ **My Physician**

Name: _____

Address: _____

Phone: _____ Fax: _____

_____ **My insurance company**

Name: _____

Address: _____

Phone: _____ Fax: _____

Please check method of release of records:

- Mail - to address or addresses identified above
- Fax - to address or addresses identified above

Patient Signature: _____ **Date:** _____

Per HIPAA regulations, we will process your request upon receiving this completed form. Thank you

COASTAL IMAGE DENTAL
3991 MacArthur Blvd., Suite 228
Newport Beach, CA 92660
Tel: (949)863-0988 Fax: (949)863-0088