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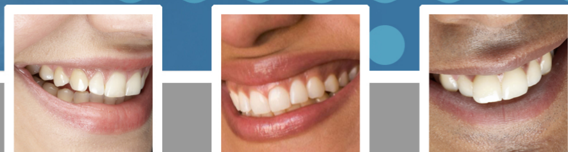

RELEASE OF RECORDS

☐ I, the undersigned, hereby request the release of dental records, medical records, and relevant radiographs, or copies of such, and request that they be transferred to: Benjamin I. Clove, DDS, PC, Clove Dental, 200 Cleveland Street, Suites C&D, Muscatine, IA 52761. If digital copies are available, please email to smile@clovedental.com.

☐ I, the undersigned, hereby request and authorize Benjamin I. Clove, DDS to disclose my clinical treatment records and financial information concerning my care to the following person:

☐ I, the undersigned, hereby request and authorize Benjamin I. Clove, DDS to disclose and provide copies of any and all clinical treatment records and information concerning my care to the following dental location:

Patient Name: ____ Last ____ First ____ MI ____ Preferred Name

Patient's Date of Birth

If Patient is a minor, name of Parent or Guardian:

Please print out form, sign it, and email it to smile@clovedental.com or fax it to 563.263.1223.

Signature of Patient or Parent/Guardian:

Response Date: