David T. Rothan, DDS, General Dentist • Michael J. Rothan, DDS, General Dentist

RELEASE REQUEST FOR MEDICAL RECORDS IF NEEDED

PHYSICIAN'S NAME____

PHYSICIAN'S TELEPHONE NUMBER___________________________________

Date of Request:	Team Member taking request:
Patient Name:	
Send Records to: **Twin Dental** **11430 Hamilton Ave** **Cincinnati, Ohio 45231**	
Date Needed By:	HIPPA Release Form Signed: Y N
Records Duplicated By:	Records Mailed By:
Patient Signature:	

**Grey areas are for Medical Doctor's office use only.*