GRU
GEORGIA REGENTS UNIVERSITY
AUGUSTA

COLLEGE of
DENTAL MEDICINE

PATIENT RELEASE OF DENTAL RECORDS CONSENT FORM

3-4 Business Days required for all duplications

As a courtesy, no fee is charged when being sent to another dentist.

--------Office Use Only--------
Recv'd:_____
Processed:_____

Records Request contact number: 706-721-9447
Once this form is completed: Fax to: 706-723-0231

OR

Mail to: GRU, College of Dental Medicine, Business Office GC1001, 1430 John Wesley Gilbert Dr., Augusta, GA 30912

Patient's Name: _____ Date of Birth: _____

Account Number: _____ Last 4 Digits of SS#: _____

Current Address: _____

Street/P.O. Box City State Zip Code

Daytime Phone Number: (_____) _____-_____

I would like to receive a copy of (please check one or both):

☐ My treatment records ($5.00)

and/or

☐ My most current x-rays ($5.00)

Please check the appropriate box below to indicate if you would like to pick up your records in person or have your records mailed to you or your dental office. There is no charge if your records are to be sent to another provider's office.

☐ Name of Patient or Dental Office:_____

Mailing Address: _____

Street/P.O. Box City State Zip Code

☐ I would like to pick up my records in person

_____ _____

Patient's (or Parent/Legal Guardian) Signature Date