



**Division of Clinical Affairs**

Patient Request for Release of Dental Record

Date: \_\_\_\_\_

I, (patient name or guardian name ) \_\_\_\_\_ authorize  
Tufts University School of Dental Medicine’s record department agent to copy and  
release to me or the following individual, \_\_\_\_\_  
a copy of my record.

I understand there is a charge of:

- \$9 - X-rays paper copies on quality paper
- \$9- X-rays on CD (JPG format)
- \$9 - Dental/Medical History Only
- \$18-Complete Record, Dental/Medical History and x-rays copies

If Records are needed for a particular date/appointment, please indicate date here: \_\_\_\_\_

Reason for request \_\_\_\_\_

Printed name (patient name) \_\_\_\_\_

Patient D.O.B. \_\_\_\_\_ Patient Telephone Number \_\_\_\_\_

Patient mailing address: \_\_\_\_\_

Signature of patient or guardian (18 years or older) \_\_\_\_\_

**Please allow up to 2 weeks for all request to be completed.**

**E -mailing requests/records is not an option.**

Please complete this release form, and mail back with your payment by check or money order.

Tufts University School of Dental Medicine

1 Kneeland Street Room 101

Boston, MA 02111

Attn: Record Department

Ph. 617-636-6824

You may fax your release form to **617-636-6858** and please call in your credit card  
payment to **617-636-6986**. We accept Visa, Master Card, and Discover Card.