

REQUEST FOR PATIENT INFORMATION - Sample

TO: (DENTIST from whom patient information is being requested.)

RE: (describe the patient information requested; include dates if pertinent)

Patient Name: _____

I, the undersigned, hereby request a copy of the above-referenced patient information.

I further request that such copy of patient information be delivered to me at this address:

OR

I further request that such copy of patient information be made available to: (name and address of the dentist to whom the copy of the patient information is to be delivered).

Date: _____

Signature: _____(qualified person)

Print Name: _____

Relationship to Patient: _____

(Some health care providers require the signature to be notarized.)

PRACTICE CLOSING Sample

Dear (Patient)

Please be advised that due to (my retirement, health reasons, etc) I am discontinuing the practice of dentistry on (DATE) . I shall not be able to attend to you professionally after that date.

Please be advised of your need for continued care. I suggest that you arrange to place yourself under the care of another dentist. If you are not acquainted with another dentist, I suggest that you contact the Third District Dental Society at 518-782-1428.

I shall make my record of your case available to the dentist you designate below. Since your record are confidential, I shall require your written authorization to make them available to another dentist. For this reason, I am including an authorization form for you to complete and return to me.

I am sorry that I cannot continue as your dentist. I extend to you my best wishes for your future health and happiness,

Very truly yours,

_____, DDS/DMD

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