Record Release Form – Lima Dental Associates

I hereby authorize Dr. _____ (Former Dentist's Name) to provide **Lima Dental Associates** with copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records, which pertain to me.

Signed: _____ (Patient/Guardian name)

Send dental records and x-rays for the following patients:

_____

_____

_____

Via fax: (419) 228-6273

Via US mail: Lima Dental Associates
2115 Allentown Rd.
Lima OH 45805