Records Request Form

I authorize Martin N. Baker DDS PA to request a copy of my/my child's dental records under the conditions and for the purposes listed below.

Patient Info:

Name: _____ DOB: _____

Address: _____

Previous Provider Info:

Office/Provider: _____ Phone: _____

Address: _____

Fax: _____ Email: _____

Information Requested:

____ Dental Chart/Notes ____ Dental Radiographs ____ History of Treatment Rendered

____ Other (Please Specify: _____)

Dates for which information is requested: From _____ to _____ or Entire Record

Purpose or need for which information is to be used:

____ Transfer of Records ____ Second Opinion ____ Other: _____

Please Release dental records for the above patient to Martin N. Baker DDS PA using one of the following methods:

Encrypted Email: office@spadds.com Fax: (252) 637-3317 Mail: Martin N. Baker DDS PA
1312 Commerce Dr.
New Bern, NC 28562

I certify that this request is voluntary and the information above is accurate to the best of my knowledge. I understand that I may revoke my authorization in writing to Martin N. Baker DDS PA. This authorization will remain in effect until revoked or the conditions are met.

Patient Name (Print): _____

Signature (Authorized Person): _____ Date: _____

Relationship to Patient (please circle): Self Parent Legal Guardian/Caretaker

*Must have copy of Legal Guardianship Papers or Power of Attorney if this authorization is signed by legal representative for patient.

MARTIN N. BAKER DDS
FAMILY DENTISTRY

1312 Commerce Dr.
New Bern, NC 28562
Email: office@spadds.com
Phone: (252) 637-1919
Fax: (252) 637-3317