

Records Release Request

Date: _____

To: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

I authorize the release of my dental and medical records, including copies of radiographs, and request they be forwarded to:

Premier Dentistry
Daniel M. Casel, D.M.D.
Goshen Village
1544 Paoli Pike
West Chester, PA 19380
(610) 696-7066

Print name of patient

Signature (patient, parent or guardian)

Patient's phone number

Social Security Number

Premier Dentistry
1544 Paoli Pike West Chester, PA 19380

I understand that I am responsible for payment of services rendered. In addition, I am responsible for paying any co-payment and deductibles that my insurance does not cover. Upon request of estimated co-payment I am aware this is an estimate and is not a guarantee of payment due. My insurance company reserves the right to not pay what is expected. If I choose to request a pre-authorization for any dental work treatment planned, I understand the insurance company may take 4-6 weeks for response and this also is not a guarantee.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____