

Patient Records Access Request Form

Chicago Smile Spa

Dr. Gerilyn Alfe DMD

2704 N. Halsted St.

Chicago, IL 60614

Phone: 773-348-2704

Fax: 773-348-6772

I hereby request a copy of my dental record as detailed below.

- Full dental record held by this office
- Dental record for the period _____ through _____
- Copy of x-rays
- A specific portion/section of the record as follows:

Forward my dental records to:

Patient Name: _____

Name: _____ Relationship: _____
(If Different From Above)

Signature: _____ Date: _____