**TODD E. PACZEWSKI, D.M.D., LCC** 1500 Wyoming Avenue Forty Fort, PA 18704 Phone: 570-287-2500 Fax: 570-288-4345

**Patient Records Access Request Form**

I hereby request/allow a copy of my medical record as detailed below

\_\_\_ Full medical record held by this office

\_\_\_ Medical record for the period\_\_\_\_\_\_\_\_\_\_through\_\_\_\_\_\_\_\_\_\_

**\_\_\_ X-Rays : From Dr Paczewski via email/fax/paper**

\_\_\_ A specific portion/section of the record as follows:\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Without your permission we are not allowed to submit your x-rays to another medical professional or yourself.**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_