



SPRING CREEK
DENTAL

422 2nd Street
Hudson, WI 54016
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Request for Access to Records and Transfer of Records

All patient dental records remain the property of Spring Creek Dental and are maintained by the office in accordance with Wisconsin State Laws. A patient may examine or obtain a copy of their records by providing signature authorization below. Please note that Spring Creek Dental reserves the right to charge a reasonable copying fee if deemed necessary.

Patient's Name (print): _____

Date of Birth: _____ (for identification purposes)

I would like Spring Creek Dental to send the copy of the requested records to:

Dental clinic name: _____

Address: _____

email: _____

Please send a copy of my dental records to Spring Creek Dental

Patient Signature: _____ Date: _____

If the request is by a patient's personal representative:

Relationship to Patient: _____ Date: _____

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of Representative: _____ Date: _____

