Patient Records Access Request Form

JAMES M. LAPIERRE, D.D.S., INC.
40 NORTH HIGH STREET
DUBLIN, OHIO 43017
(614) 889-1133

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

_____ Full medical record held by this office

_____ Medical record for the period _____through_____

_____ A specific portion/section of the record as follows:

_____

_____

_____

Patient Name: _____

Name:_____
(if different from above).

Relationship: _____

Signature: _____

Date: _____