Art of Pediatric Dentistry

RECORD RELEASE FORM

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they are transferred to:

TO: ____

ADDRESS: ____

CITY:______________________________ STATE:________________ ZIP:_______________

Records Requested:____

Name of Patient : ____ Date of Birth:_________

Name of Patient : ____ Date of Birth:__________

Name of Patient : ____ Date of Birth:__________

Signature of Parent/Guardian:____

Date: ____________________________