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PEDIATRIC DENTISTRY

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Records Release Form

Please complete this form if you are changing dental practices or requesting records for any other reason.

I,_____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be sent to:

Name: _____
Address: _____
Phone: (____) _____
Fax: (____) _____
Email: _____

For the purpose of: _____
_____

Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____
Name of Patient: _____ DOB: _____

Records being requested:

( ) Current radiographs ( ) Chart Notes ( ) Treatment Record ( ) Insurance Information
( ) Other: _____
_____

Signature of Parent/Guardian: _____ Date: _____