

# RECORD RELEASE FORM

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be 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: \_\_\_\_\_