RECORD RELEASE FORM

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

_____

_____

_____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Records being requested:

( ) Current radiographs

() Other: _____

_____

Signature of Parent/Guardian: _____ Date: _____