Authorization to Release Patient Records

Previous Practice Name: _____

Address: _____

Number: _____

I hereby authorize and request Dr. _____ to release all dental records, including, but not limited to, treatment records, medical information and all radiographs for the following patient(s):

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

Send to: **ABC Pediatric Dentistry**
6908 South Lyncrest Place
Sioux Falls, SD 57108
or
amaliaabcdental@gmail.com

**please send all digital images via email.*

_____
Print Parent / Legal Guardian Name

_____
Parent / Legal Guardian Signature Today's Date

Thank you in advance for your cooperation in this matter!