Record Release Form

Date: _____

I, _____ authorize The Kid's Dentist to release dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

_____

_____

Email:_____

I understand that a $10.00 fee will be charged to me prior to the release of the information.

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Signature of Parent/Guardian: _____ Date: _____

Address: _____

_____