Request for Release of Records

I _____ (Parent/Guardian) hereby authorize the release of dental records for _____ (Patient).

I _____ hereby authorize the release of my dental records.

Please send records to the following location:

_____
_____
_____

I will accept the records myself.

Fee collected for records duplication: _____

Records received:

- X - rays
- Progress Notes
- Treatment Plans

Signature: _____ Date: _____