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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 ☐Dental Health Status ☐Reports ☐Diagnostic Casts ☐Treatment Record

☐Charts ☐Health History ☐Prescription Records ☐Photos ☐other:

Signature of Parent/Guardian: _____ Date: _____