



RECORDS AND XRAY RELEASE REQUEST

Date: _____

I, _____ (Parent/Guardian) of

_____ (Child/Children) Authorize the release of dental, medical records and xrays relevant to dental Treatment, or copies/duplications of such, and request they be transferred to:

Dentist's Name _____

Address _____

City/State/Zip Code _____

We charge a \$25 non-refundable duplication fee. Release of records will take 2-3 weeks to be sent to new provider. Account balance must be at zero before records/xrays can be released.

Signature of
Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Relationship _____