Dental Record Release Authorization

I, _____ am legal representative for_____ and authorize the release of dental records.

Signature: _____ Today's Date: _____

Relationship to Patient: _____ Phone: _____

Patient Name: _____ Date of Birth: _____

Please Forward Record To:

Name: _____

Address or Email: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Reason for record request: _____

Records needed by: _____ _____

PLEASE NOTE: All Release forms must have a copy of the Parent/Guardian's photo ID attached or records will not be released. Allow two business days for the records to be available. Unless instructed otherwise, we will provide radiographs only.