Authorization for Release of Dental Records

I authorize the release of my children's dental records to:

_____

(Name of Dentist or Clinic)

_____

(street address) (city) (state) (zip)

_____

(phone number) (fax number)

_____

(email address)

Patient Information:

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

Signature of Parent/Legal Guardian **Date**