

PEDIATRIC DENTAL ASSOCIATES

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Release of Records

Please transfer copies of my child(ren)'s dental treatment records, including diagnostic x-rays and any other materials, notes or copies of medications prescribed. I understand that original records and x-rays are the property of Pediatric Dental Associates. I agree to accept copies and to pay reasonable fees for such copies as deemed necessary by the office.

Name of Patient(s): _____ DOB: ____/____/____
_____ DOB: ____/____/____
_____ DOB: ____/____/____

Date of Request: _____ Date required by: _____

Release to:

Mr./Mrs. _____
Address: _____
City: _____
State/Zip: _____
Phone: _____

OR

Transfer to:

Dr. _____
Address: _____
City: _____
State/Zip: _____
Phone: _____

Parent / Guardian Signature: _____ Date: _____