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www.kidsonlydentalplace.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's name: ______________________ Date of Birth: ______________

Patient's name: ______________________ Date of Birth: ______________

Patient's name: ______________________ Date of Birth: ______________

From Prior Office to Kids Only Dental Place

I authorize transfer of all records, including treatment history and x-rays, to Kids Only Dental Place for the above named children.

Office Name: ______________________

Phone #: ______________________

Email Address: ______________________

Parent's Name: ______________________

Signature: ______________________ Date: ______________

From Kids Only Dental Place to New Office

I authorize transfer of all records, including treatment history and x-rays, from Kids Only Dental Place for the above named children.

Office Name: ______________________

Phone #: ______________________

Email Address: ______________________

Reason for leaving: Relocation: _______ 2nd Opinion: _______ Insurance: _______

Other: _______ (please explain to help us better serve others in the future)

____

____

Parent's Name: ______________________ Date: ______________

Signature: ______________________

If faxing release to our office, please include a copy of your driver license.