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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.