Authorization for Release of Records

Pediatric Dental Associates

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Please complete one release per patient

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient's Parent/Representative Date

_____ _____
Printed Name Relationship to Patient

Purpose of Records Request/Release:

___ Transferring to Another Dentist
___ Moving out of Local Area (Departure Date) _____
___ Other (Please Specify) _____

Method of Records Transmission for X-rays: (circle one) Mail Pick-up Email

Method of Records Transmission for Procedure History: (circle one) Mail Pick-up Fax

Send Records To: Mr /Mrs/ Ms/ Dr: _____

Address _____

City _____ State _____ Zip _____

Phone (_____)_____-_____ Fax (_____)_____-_____

Email_____

When: (circle one) ASAP (1 week minimum) Upon Notification Date_____

For Office Use: Records Prepared & Sent/Delivered By _____ Date _____
___ Procedure History & Tooth Chart
___ Diagnostic x-rays taken within past 6 months
___ Panoramic x-rays taken within the past 3 years
___ Other _____