AUTHORIZATION TO FORWARD OR REQUEST RECORDS

PEDIATRIC DENTAL ASSOCIATES, LLC

330 E Tudor Road Anchorage, AK 99503
Phone: (907) 522-1991 or (907) 522-1567
Fax: (907) 344-9036 E-mail: info@pediatricdentalak.com

_____ _____
Patient name Date of birth

_____ _____
Patient name Date of birth

_____ _____
Patient name Date of birth

FORWARD RECORDS

I authorize Pediatric Dental Associates, LLC to forward my dental records:

To:_____

Address:_____

Phone:_____ Fax:_____

E-mail:_____@_____._____

When: (circle one) ASAP (1 week minimum) Upon notification

REQUEST RECORDS

I authorize Pediatric Dental Associates, LLC to request my dental records:

To:_____

Address:_____

Phone:_____ Fax:_____

E-mail:_____@_____._____

Scheduled appointment on:_____

_____ _____
Signature of authorized person Date

_____ _____
Printed name Relationship to patient

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 _____