AUTHORIZATION TO FORWARD OR REQUEST RECORDS

PEDIATRIC DENTAL ASSOCIATES, LLC

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| Patient name | | Date of birth |
|-------------------|--|--|
| Patient name | | Date of birth |
| Patient name | | Date of birth |
| I autho | FORWARD RECO | |
| To: | | |
| Address: | | |
| Phone: | | Fax: |
| E-mail: | | @· |
| When: (ci | rcle one) ASAP (1 week minimu | · |
| То: | | to request my dental records: |
| Phone: | | Fax: |
| E-mail: | (| @ |
| Scheduled | appointment on: | |
| | | |
| Signature of auth | orized person | Date |
| Printed name | | Relationship to patient |
| | For Office Use: Records Prepared & Sent/Deliv Procedure History/Tooth Diagnostic x-rays taken v Panoramic x-rays taken v Other | n Chart within past 6 months within the past 3 years |