Peninsula
Pediatric Dentistry

Authorization for Release of Dental Records

Today's Date: _____

Patient Current Address: _____

Phone: _____

Patient(s) Name and Date of Birth: _____

Requesting: Records and x-rays _____ Pano only _____ x-rays only _____

Records to be: Mailed _____ Picked Up In Office _____ Faxed _____ on_____

I authorize _____to release my records to Peninsula Pediatric Dentistry

Phone: _____

Address: _____ Fax: _____

I authorize Peninsula Pediatric Dentistry to release my records to:

Dr.'s Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Reason for request:

Referred out: _____ Moving: _____ Other: _____ (Explain)_____

_____

_____

Signature of Patient or Guardian: _____

Staff Initials: _____ Date Records mailed or picked up: _____

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