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Pediatric Dentistry

# Authorization for Release of Dental Record and X-rays

Patients's Name: _____ DOB: _____

**I, _____ request that your office release copies of:**

( ) Most recent dates of cleaning, exam, x-rays and brief dental history
( ) X-rays enclosed if bitewings are within one year, panoramic within five years
( ) All records

**Send records to:**

Dental clinic _____

Street Address _____

City, ZIP code _____

Practice Phone Number _____

Practice E-mail Address _____

**Reason for leaving our office:**

_____

_____

**Signature** _____ **Date:** _____

Please Note: *These copies may be electronic or print submissions*