Authorization for Release of Dental Records and X-rays

I, (guardian name) ______________________, hereby authorize the doctors and staff of Pediatric Dental Healthcare to release (patient name) ______________________ records, x-rays or knowledge concerning my dental health to:

Office name ____

Email address ____

Street address ____

City, Zip Code ____

Practice telephone # ____

Please circle the following requested. I specifically request that you release copies of:

x-rays **dental records**

Signed (patient or guardian name) _____________________ Date: ________________

Printed name (patient or guardian name) ______________________________________

Please complete the form and email to Patientinfo@pediatricdentalhealthcare.com or fax to (508) 695-8492. Once the release has been completed it usually takes 3 to 7 days to duplicate and send over records.

16 Washington Street (Rt.1) Plainville, MA 02762
www.PediatricDentalHealthcare.com 508.695.2064
www.BracesForKids.com