Release of dental records FROM

Young Kidz Dental & Todd Young, DDS

I, ____,

(PARENT/GUARDIAN)

authorize the staff of Young Kidz Dental to release dental records for :

____

(PATIENT'S NAMES/DOB)

Please release my records to:

Practice/Doctors name: ____

Email address: ____

Phone: ______________________

Fax: ________________________

Please release copies of:

_________ Current x-rays and dates

__________ Most recent service dates for recall services

Reason for transferring ____

____

Printed Name: ______________________________Date: _____________________

Signature: ____

(PARENT/GUARDIAN)