

**Release of dental records TO  
Young Kidz Dental & Todd Young, DDS**

I, \_\_\_\_\_,

(PARENT/GUARDIAN)

authorize the staff of \_\_\_\_\_

(PREVIOUS DENTAL OFFICE)

to release dental records for my child/ren:

\_\_\_\_\_  
(PATIENT'S NAMES/DOB)

To: Young Kidz Dental

14210 SE Sunnyside Road #100

Clackamas, Oregon 97015

503-658-3384 [info@youngkidzdental.com](mailto:info@youngkidzdental.com)

Please release copies of:

\_\_\_\_\_ Current Dental x-rays

\_\_\_\_\_ Treatment History

Reason for transferring \_\_\_\_\_

\_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

(PARENT/GUARDIAN)