

Release of dental records FROM
Young Kidz Dental & Dr. Kasey Hall

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 servies

Reason for transferring _____

Printed Name: _____ Date: _____

Signature: _____

(PARENT/GUARDIAN)