The Kids' Dentist

Release of Records

Today's Date: (MM/DD/YYYY)

Child's Name:

Date of Birth: (MM/DD/YYYY)

☐ Please forward my child's records to the following dentist, including diagnostic x-rays and any other pertinent information.

Send to: Dr.

Address:

City/State/Zip

☐ Please provide me with copies of my child's dental records, including diagnostic x-rays and any other pertinent information. I understand that original records and x-rays are the property of The Kids' Dentist.
I agree to accept copies and to pay reasonable fees for such copies. If originals are given, I agree to return them to The Kids' Dentist after our new dentist views them.

I have read and understand the above information and the instructions given to me verbally. By my signature below, I indicate my agreement with the above.

Signature: _____ Date:

Witness: _____ Date: