Records Release

Record Release Authorization
Patient (s) Name:
_____

Patient Date Of Birth: _____
Parent Name:
_____

I hereby authorize and request the following provider to disclose my child's dental records and give copies to Burbank Kids Dental:

_____

_____

Please release any and all records and information which you may have in your possession, including but not limited to the following; dental records including operative records, diagnosis, dental history, findings and procedures, treatment notes, radiographs, diagnostic models and additional materials.

In consideration of such disclosure on the part of the above named parties, I hereby release them from any and all liability arising from such disclosure.

Parent Signature _____ Date _____
**Reason for request of records:
_____
_____
_____