Record & X-Ray Release Form

I hereby authorize Central Park West Pediatric Dentistry to release the following for

____
(Name of Patient)

☐ X-rays
☐Records
☐Models
☐Other: _________________

To the following person(s):

☐Parent/Guardian
☐ New Dentist
☐Other: ___________________

____
Name of Patient or Parent/Guardian

____
Signature of Patient or Parent/Guardian

Why are you requesting records?

____

Date: ____

***New Dentist information**
Name of Dentist: _____________________________________

Telephone: ____

Address: ____

City: _____________________ State: _________ Zip_________