



RECORDS RELEASE

In compliance with HIPPA guidelines, I formally request release of my child's records to the organization, agency or individual named below.

Please duplicate my child's dental records and forward to our dentist at the following address:

Name of New Dentist: _____

Email Address of New Dentist: _____

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Parent / Guardian Signature

Date

Print Name

FOR OFFICE USE	
HIPPA Compliance:	_____
Parent Contacted:	_____
Account Balance:	_____