AKD

All·Kids·Dental

PEDIATRICS & ORTHODONTICS

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: _____
(if email is unavailable, you may list a fax number or mailing address) _____

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

_____ _____
Parent / Guardian Signature *Date*

_____
Print Name

FOR OFFICE USE

HIPPA Compliance: _____

Parent Contacted: _____

Account Balance: _____