



Date:

REQUEST FOR RELEASE OF RECORDS

I (Patient's Name) _____ hereby request and give my permission to Dr. _____ to provide

Dr _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

any and all information which he/she may request with respect to the orthodontic care of
(Patient) _____.

Such records may include medical care and treatment, illness or injury, dental history, medical history, consultation, prescriptions, x-rays, models and copies of all dental records and medical records.

I agree to pay the cost of duplicating any records. A photocopy of this release will be as effective and valid as the original.

Signed: _____ Date Signed:

(Patient)

S.S.N./S.I.N.: _____

Phone: (_____) _____ - _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Signed: _____ Date Signed:

(Parent, Legal Guardian or Custodian of the Patient, if appropriate)

Phone: (_____) _____ - _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____