



RELEASE OF RECORDS

Child's Name: _____ Date of Birth: _____

- Please forward my child's records to the following dentist, including diagnostic x-rays and any other pertinent information.

Send to: Dr. _____

Address: _____

City/State/Zip: _____

- Please provide me with copies of my child's dental records, including diagnostic x-rays and any other pertinent information. I understand that original records and x-rays are the property of Kids Dentist. I agree to accept copies and to pay reasonable fees for such copies. If originals are given, I agree to return them to Kids Dentist after our new dentist views them.

I have read and understand the above information and the instructions given to me verbally. By my signature below, I indicate my agreement with the above.

Patient Signature _____ Date _____

Witness _____ Date _____

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Grayslake, IL * (847) 223-1400