



Authorization for Release of Dental Records and X-rays

I, (guardian name) _____, parent or legal guardian
of (child's name) _____ hereby authorize the
doctors and staff of **Kids Dental Care** to release records or knowledge concerning my
child's dental health to:

Doctor or Practice name _____

Street Address _____

City, Zip Code _____

Practice telephone number _____

Please state your reason for transfer:

Patient's Name: _____

Signature (Parent/Guardian) _____ **Date:** _____

Print Name _____ **Relationship:** _____