Request for Release of Records

To: _____

_____

I hereby request that dental records and x-rays of patient listed below be released to:

Children's Dentistry, P.A.

200 Village Square Xing, Suite 101

Palm Beach Gardens, Fl 33410

Phone 561-626-9887

Email: info@drmimy.com

Fax 561-627-4451

Please email, Fax or mail records at your earliest convenience.

***********Patient Information**********

Name:

DOB:

_____ _____

Signature of parent or legal guardian Date

_____ _____

Name of parent or legal guardian Relationship to Patient