<u>RECORDS RELEASE REQUEST</u>

Patient's Name: ____

Address: ____

City: __________________ State: ______________ Zip: ______

I, ___________________________, __________________ of ______________________,
(Parent / Guardian Name) (Relationship to the Patient) (Patient's Name)

Hereby authorize the release of the x-rays and records and request that the copies be sent to:

Doctor / Hospital / Parent (Circle One): __________________________

Address: ____

City: __________________ State: ______________ Zip: ______

I fully understand that upon signing this form, my child will no longer be a patient of record of ToothTown Pediatric Dentistry.

____ ____________________

PARENT / LEGAL GUARDIAN'S SIGNATURE DATE

Please fill out this form and fax it signed to our office at (561)791-8603.