REQUEST FOR TRANSFER OF DENTAL RECORDS

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I, ________________________________, authorize the release the of following
Parent Name
records for my child/children, to: ____.
Receiving Dr.'s Name

__________________________________ ____________________
Child's Name Date of Birth

__________________________________ ____________________
Child's Name Date of Birth

__________________________________ ____________________
Child's Name Date of Birth

__________________________________ ____________________
Child's Name Date of Birth

X-rays _____
Medical History _____
Patient Chart _____

__________________________________ ____________________
Parent/Guardian Date

__________________________________ ____________________
Receiving staff member Date