Dental Records Release Form

Patient Name to Transfer: ___________________________________ Patient Date of Birth: ____ /____ /____

Other Family Members to Transfer: ____

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Please release dental records for the patient(s) listed above to the following Dental/Medical Office.
(Please include email address and/or mailing address.)

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Parent/Legal Guardian Acknowledgement of Release of Records: By signing, I authorize Lamorinda Tooth Buds – Pediatric Dentistry to release necessary radiographs and records to healthcare providers involved in the care of the patient listed above.

Parent/Guardian Signature: ____ Date: ____ /____ /____

□ Please send me a copy of the radiograph via unencrypted email.

________ ____

Initials Email address