Charm City Smiles
Your Wellness, Our Priority

RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

_____

_____

_____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Name of Patient:_____ Date of Birth: _____

Records being requested:

( ) Current radiographs	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Record	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos

() Other: _____

_____

Signature of Parent/Guardian: _____ Date:_____