PEDIATRIC & ADOLESCENT DENTISTRY

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient's Name:_____ DOB:_____

Date of last examination: _____

Date of last prophylaxis and fluoride treatment: _____

Date of last BW: _____

Date of last O-pan: _____

Sealants: _____

Other information:

_____

_____

_____

Records will be released from : _____

To Office or Dentist name: _____

Address: _____

_____

E-mail address: _____

Appointment Date: _____

_____ _____

Signature Date

_____ _____

Relationship Daytime telephone number