release of records

northeast iowa PEDIATRIC DENTISTRY

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Today's Date: _____

I authorize the release of my child(ren)'s dental records to:

Dental Office Name: _____

Address: _____

_____

Patient Name(s): _____DOB: _____

_____DOB: _____

_____DOB: _____

_____DOB: _____

_____DOB: _____

_____ _____

Signature of legal guardian/parent Date

_____

Relationship to patient(s)