HEALTHY SMILES 4 KIDS, PC

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RECORDS AND XRAY RELEASE REQUEST

Date:_____

I, _____(Parent/Guardian) of

_____(Child/Children)

Authorize the release of dental, medical records and xrays relevant to dental

Treatment, or copies/duplications of such, and request they be transferred to:

_____
Dentist's Name

_____
Address

_____
City State Zip Code

We charge a $25 non-refundable duplication fee. Release of records will take 2-3 weeks to be sent to new provider. Account balance must be at zero before records/xrays can be released.

_____
Signature of Parent/Guardian Date

_____
Printed Name of Parent/Guardian Relationship