

COLLEYVILLE CHILDREN'S DENTISTRY
5708 Colleyville Blvd., Suite A
Colleyville, TX 76034
817-428-8575; Fax 817-577-3970

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