OASIS

Pediatric Dental Care & Orthodontics

Dental Records Release Request

Date:__________

Patient Name: ____________________ **Patient DOB:** ___________________

Patient Phone: ____________________

Release of: (Please Circle)

Dental Records & X-rays **Only X-Rays (For Referrals)** **Orthodontic Records & X-Rays**

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Please forward any of the following information on record:

To:

Dentist or SELF: _____________________________________ **Phone Number:** _____________________

Address: ____

City/ St/Zip: ____

Email: ____

I hereby give you permission to release any and all of my dental records

____________________________________ ____________________

Patient Signature **(parent if a minor)** **Date**