Request for Release of Dental Records

Date: _____

From: _____
Doctor/Office

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

I, _____ parent/legal guardian (patient age 18+), authorize the release of all records relevant to dental treatment, or copies of such.

I understand/acknowledge that the above mentioned doctor and office staff are not responsible for the confidentiality or security of any correspondence delivered via e-mail, FAX, U.S. Postal Service, or hand carried. Please transfer records to the following:

To: Andrew D. Chandler D.D.S. /PC – Augusta Children's Dental Center
Doctor/Office

Address: 525 Pleasant Home Road

City: Augusta State: GA Zip: 30907

Phone: (706)860-6443 Fax: (706)855-0426

Email: DrAndy@augustakidsdentist.com

_____/_____
Print – Patient's Name Date of Birth

_____
Signature - Parent/Legal Guardian ***or*** Patient's Signature (age 18+)