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every tiny tooth is precious :)

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### Patient Record Release Form

Date : \_\_\_\_\_  
(mm/dd/yyyy)

Patient's Name : \_\_\_\_\_ D.O.B. \_\_\_\_\_  
(mm/dd/yyyy)

I \_\_\_\_\_, request the dental records and dental  
(Parent/Guardian Name)  
radiographs taken on my child to be release to me.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

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#### OFFICE USE:

Date Released: \_\_\_\_\_

Method of Release:            Mail            Parent Pick-up

Released by: \_\_\_\_\_