Dentistry for Children

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Release of Records

I, _____hereby authorize Dentistry for Children to release _____ dental records. These records may include x-rays, treatment notes, charting, medical and dental history, photographs, or other notations relevant to my treatment.

These records may be released to: (Circle One)

1. My dentist / doctor: _____

Address or e-mail _____

_____

2. Sent to my home address.

3. Released to person authorized by me: _____

4. Personally picked up records today.

_____ _____

Signature Date

Fax# for Creve Coeur 314-567-0260 Email: STL@dentistryforchildrenstl.com

Fax# for St. Charles 636-946-5005 Email: STC@dentistryforchildrenstl.com