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# AUTHORIZATION TO RELEASE DENTAL RECORDS

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth _____

I request and authorize Kidsmile, Inc. to send the dental records of the patient(s) named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Kidsmile, Inc. may request a $25.00 duplication fee before releasing dental records; however, there are no fees for records transferred to another dental office. Duplication of records will be processed within 30 days of receipt of request.

I authorize Kidsmile, Inc. to duplicate, use or disclose my protected health information to the address above.

_____ _____
Parent/Legal Guardian Signature Date

Revised 2/4/13