

JASON C. BARB, DDS TODD BERNARD, DMD JOHN M. VENZEL, DMD

Authorization to Release Dental Records

Patient's Name:	Birthdate:
Patient's Name:	Birthdate:
Patient's Name:	Birthdate:
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. 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 5/2019

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