

NEWTOWN SMILE DENTISTRY

RECORD RELEASE FORM

I, _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Records being requested:

Current radiographs Dental Health Status Reports

Diagnostic Casts Treatment Record Charts

Health History Prescription Records Photos

Other: _____

Signature of Parent/Guardian: _____ Date: _____