PEDIATRIC SPECIALISTS

Dentistry FOR CHILDREN

DRS. DILL, VARBLE & WONG

Release of Records

I, _____, hereby authorize Dentistry for Children to release the dental records of _____. 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

Creve Coeur

Fax: 314-567-0260

STL@dentistryforchildrenstl.com

St. Charles

Fax: 636-946-5005

STC@dentistryforchildrenstl.com