AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS

I, (print parent or guardian name) ____,
hereby authorize the doctors and staff of Sunnyside Dentistry for Children, PC to release dental records for:

____________________	____________________	____________________	____________________
(patient name)	(patient DOB)	(patient name)	(patient DOB)
____________________	____________________	____________________	____________________
(patient name)	(patient DOB)	(patient name)	(patient DOB)

To: Full Dr. Name: ____

Address: ____

City, State, Zip: ____

Telephone: ___________________________ Fax: ____________________________

Email: _________________________________@________________________________

I specifically request that you release copies of:

__________ Current Dental x-rays (Including panoramic films and other exposures less than 12 months ago

__________Treatment History (Including services rendered and dates of service)

Reason for transferring____

I hereby consent to the release of the above information. I understand that such information cannot be released without my consent.

Printed Name: _______________________________Date: ______________________

Signature: ____

Patient (over age 18), parent or guardian name

A photocopy or fax copy of this release is as valid as the original. This release form is valid for 6 months from the signed date.

This form may be sent to Sunnyside Dentistry for Children via fax number 503-826-5196 or emailed to info@sunnykids123.com