



D E L U N A
 k i d s
 D E N T A L

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RELEASE OF DENTAL RECORDS

I _____ authorize the release of
 (parent's name)

dental records and x-rays for _____
 to: (child / children's name)

- o Yourself
- o Other dental office

Reason for record release

- o Second opinion
- o Moving
- o Changing dentist
- o Insurance change

Signature _____

Date _____