Redwood City Pediatric Dentistry

AUTHORIZATION TO RELEASE PATIENT RECORDS

I, _____, hereby authorize and request Redwood City Pediatric Dentistry to release to:

_____

Name of Dentist

_____

Address

_____

City State Zip

All dental x-rays and/or any pertinent information of:

Patient's Name	Date of Birth

I hereby release Redwood City Pediatric Dentistry from any liability related to disclosure of confidential or privileged information and understand that Redwood City Pediatric Dentistry will be available for emergencies for thirty(30) days from the date of this record release, but not thereafter.

Signature of Parent or Guardian Date

Address

Please respond by fax (650.365.2690) or email (redwoodcitypediatricdentistry@gmail.com).