Sugar Bugs Pediatric Dentistry
Tandi V. Donaldson, DDS, MS
Julie V. Vuong, DDS
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Arvada, CO 80003
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

****PLEASE ALLOW UP TO 5 BUSINESS DAYS, THANK YOU.****

I hereby authorize Dr. Tandi Donaldson and Dr. Julie Vuong to release dental records on:

Patient Name and DOB:_____

Patient Name and DOB:_____

Patient Name and DOB:_____

Patient Name and DOB:_____

Address:_____Phone:_____

City:_____State:_____ Zip Code:_____

PERMISSION TO RELEASE (Please initial ONE):

_____ ONLY Dental Xrays/Records taken at Sugar Bugs Pediatric Dentistry

_____ Dental Xrays/Records taken at Sugar Bugs Pediatric Dentistry **AND** any other dental providers

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RELEASE TO:

Name: _____

MAIL TO: Address: _____

City:_____State:_____ Zip Code:_____

OR EMAIL TO:_____

Printed name of Responsible Party (Parent): _____

Signature:_____Date: _____

Reason for records request: _____2nd opinion _____transferring due to age

_____transferring elsewhere due to: _____

Appointment scheduled? Y N If yes, Appointment date: _____

********** FOR INTERNAL USE ONLY**********

Date request received: _____ By (initials): _____