

Sugar Bugs Pediatric Dentistry

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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 Taylor 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

REQUIRES SIGNATURE AT BOTTOM, THANK YOU.

.....
RELEASE TO:

Name: _____

MAIL TO: Address: _____

City: _____ State: _____ Zip Code: _____

OR EMAIL TO: _____

Reason for records request: _____ 2nd opinion _____ transferring due to age
_____ transferring elsewhere due to: _____

*****Appointment scheduled at New Dentist? Y N If yes, Appointment date: _____**

*****Printed name of Responsible Party (Parent): _____**

*****Signature: _____ Date: _____**

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

Date request received: _____

By (initials): _____