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 Sugar Bugs Pediatric Dentistry 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:_____

RELEASE TO (We will send by email. *If you don't know the email, the Phone# is required*):

PLEASE PRINT CLEARLY

NAME: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

****

Reason for records request: _____2nd opinion _____transferring due to age

_____transferring elsewhere due to: _____

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

By signing, I give Sugar Bugs Pediatric Dentistry permission to send xrays/records to the dental practice/person listed above.

****Print name of Resp. Party (Parent/Patient):** _____

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

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

Date request received: _____ By (initials): _____