Request for Release of Records

To: _____

_____

I hereby request that dental records and x-rays of patient listed below be released to:

Stuart Pediatric Dentistry
900 S.E. Ocean Blvd, Suite B-118
Stuart, FL 34994
Phone: 772-600-5130
Fax: 772-600-5523
Email: info@stuartpediatricdentistry.com

Please email, fax or mail records at your earliest convenience.

******Patient Information******
Name:
DOB:

_____ _____
Signature of parent or legal guardian Date

_____ _____
Name of parent or legal guardian Relationship to patient