

Kalispell Kidds

Pediatric Dentistry

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND RADIOGRAPHS

I, (print parent/guardian name) _____, hereby authorize the dentist and staff of Kalispell KiDDS to release my child's/children's dental records and/or radiographs. I understand all future appointments with Kalispell KiDDS will be canceled unless otherwise requested.

Patient Name(s):

1. _____	DOB: _____
2. _____	DOB: _____
3. _____	DOB: _____
4. _____	DOB: _____

Contact phone number (if any questions): _____

Please transfer records to:

Practice/Dentist Name _____
Street Address _____
City, Zip Code _____
Telephone _____
Office Email _____

Signature of parent/guardian: _____ Date: _____

Printed Name/relationship to child: _____

Please complete this form and fax it to (406) 756-1143

FOR DENTAL OFFICE USE ONLY:

- Request for access denied (attach written denial)
 Request for access approved. An electronic copy was provided.

Radiographs sent: _____ Email: _____ Date: _____