LITTLE smiles PEDIATRIC DENTISTRY

Dental Records Release Form

Patient Name to Transfer:_____

Date of Birth:_____

Other Family members to transfer:_____

_____

Please release dental records for the patient listed above to the following Dental/Medical Office (please include email address and/ or mailing address):

_____

_____

I hereby give Little Smiles Pediatric Dentistry permission to release all dental records, including x-rays, charting, and photographs to the dental/medical provider listed above.

Parent/Guardian Signature:_____

Date:_____

After signing and dating this form, you can bring it by our office, fax it to us, or scan and email it.

Address: 205 Denali Pass. Suite A
Cedar Park, TX 78613

Fax: 512-528-9124

Email: drjennysmiles@yahoo.com